

WONCA News

An International Forum for Family Doctors



CONTENTS

From the Wonca President : the theme is team: Primary Health Care in Chile	3
From the CEO's Desk : the Wonca website - time for a revamp?	6
From the Editor : the president's travels	7
Nominations for Wonca 5-star doctor awards	8
SPECIAL FEATURE : "Divided we fail": Harveian oration 2011 - Dr Iona Heath	9
FEATURE STORIES : EUROPE IN FOCUS	11
<ul style="list-style-type: none"> • 17th Wonca Europe conference: report from Warsaw • Wonca Europe Executive board and council report • Wonca Europe - journal receives 'impact factor' in 2012 • European definition of general practice: 2011 revision • IPCRG and Wonca Europe agreement of collaboration 2011-14 • The European General Practice Research Network explained • News from EQUIP to Wonca world 	
WONCA REGIONAL NEWS	21
<ul style="list-style-type: none"> • AP region executives visit China • December 2011 deadline for Europe and AP conference abstracts • Wonca Asia Pacific Jeju 2012 • Inaugural Rajakumar Movement pre-conference in Jeju 	
WONCA WORKING GROUP NEWS	24
<ul style="list-style-type: none"> • Working Party on Ethical Issues plan for Vienna 2012 • Profile: Manfred Maier - Chair Wonca working party on ethical issues • Rural rendez-vous 2012 	
MEMBER AND ORGANIZATIONAL NEWS	27
<ul style="list-style-type: none"> • SemFYC and CIMF meet in Spain • AAFP global health workshop: students add value • AAFP's new president's message for family physicians • News from Canada / Des nouvelles du Canada • Profile: Julio Ceitlin, honoured by CFPC / honoré par CMFC 	
RESOURCES FOR THE FAMILY DOCTOR	34
WMA statement on the global burden of chronic disease	
WONCA CONFERENCES 2011-2013 AT A GLANCE	37
GLOBAL MEETINGS FOR THE FAMILY DOCTOR	38

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FROM THE WONCA PRESIDENT :

THE THEME IS TEAM: PRIMARY HEALTH CARE IN CHILE

Chile is a country of contrasts. Down the length of the nation, the heights of the Andes are only a short distance from the depths of the Pacific. Chileans (“Chilenos”) are friendly and direct, yet self-doubting and cautious.

In October, I was invited to Chile to speak at the annual meeting of the Sociedad Chilena de Medicina Familiar (SOCHIMEF), which attracted approximately 250 registrants. Especially enjoyable was the chance to visit with about 100 representatives of 12 Latin American countries, at a meeting of the young family doctor movement known as Waynakay, Quechua for “youth.”



Picture of a funicular in Vina del Mar, where the SOCHIMEF annual meeting was held.

I had been to Chile before, but during this week long trip I was able to see more of the country and to spend more time examining primary health care. My visit to Chile reminded me of the importance of the primary health care team. Few national health systems have put as much thought and effort into primary care teams as has Chile.

The context

First, I should offer a few reflections about Chilean history and its health system. Always present, but not often discussed, is the painful history that has shaped modern Chile. The politics of late 20th century Chile reflected the excesses of both the left and right, from

the expropriations, hyperinflation, and people’s militia of Allende to the Caravan of Death (death squads) and Desaparecidos (“disappeared”) of Pinochet. Understandably, these deep wounds have still not healed in Chile, which is why few Chilenos wanted to revisit that history when I asked them. Yet, to understand a country’s health system, it is first necessary to understand its history and context.

Built on mining and agriculture, Chile is viewed today as one of the most stable and prosperous countries in Latin America, with the highest per capita income in the region. In 2010, it was the first country in Latin America admitted to the OECD (Organisation for Economic Co-operation and Development). At the same time, Chile has significant income inequality, with about one in four living in poverty.

The concept

The first family doctors were trained in Chile in 1982. After 17 years in control, the Pinochet government left power in 1990. The overlap of the two events is not coincidental. Arising out of a public health tradition, the primary health care system (“APS” or Atención Primaria de Salud) was designed to serve as a safety net for the poor and to promote equity. The APS system is funded and governed primarily by the municipalities. APS services are generally free to the user. As the gap grew between rich and poor during the Pinochet years, APS was one way to reduce the disparities. Primary health care teams (“equipo de APS”) were constructed carefully to avoid the arbitrary rule of a few dictators and to advance the ideals of democracy and egalitarianism – everyone on the team was important.

Given the substantial number of poor Chilenos, the APS strategy has worked. The WHO report published in 2000 that compared the world’s health systems ranked Chile 21st for health outcomes and 33rd for overall performance. Chile’s achievements in maternal and child health have been especially notable.



Photo of a typical home in middle class portion of Santiago.

About three out of four Chilenos depend on the public health system, which is centered on APS. There are two APS doctors per 1000 people, which works out to about 25,000 doctors in APS, only 500 of whom are trained family doctors – most are general doctors. Across Chile, there are slightly more than 1900 APS units and 183 hospitals with 26,000 beds. The six public and 12 private medical schools graduate about 800 physicians annually, only about 5-10% a year choose a residency in Family Medicine. An APS doctor earns about USD 2000 per month for 20 hours per week working in the APS unit. While some family doctors are full-time public employees in APS, most work another 20 hours per week or so in the private sector, where they typically earn another USD 3700 per month.

The culture

The national health strategy includes nine objectives, 50 metrics, and 513 indicators, which can be found at <http://deis.cl/minsal>. I believe that a large part of the success of the Chilean health system can be attributed to its APS strategy. Targets for routine services that everyone should receive (immunizations, prenatal visits, etc.) are achieved with considerable dependability. APS teams are multi-disciplinary and consist typically of a doctor, dentist, nurse, midwife, and community health worker, along with ready access to mental health workers and other professionals. Teams participate together in a certification program that is taught on Friday afternoon and Saturday every two weeks for nine months. One Saturday, I was able to watch the various teams learning together as they worked through case presentations and discussed the philosophy and tactics of primary health care.

I spent an afternoon watching a compassionate family doctor, Dra Paola Rodriguez, as she consulted with patients. During one consultation, she diagnosed a nine year old girl's cough as seasonal allergies and prescribed chlorpheniramine. She then turned to the girl's 65-year old grandmother who had brought her to the doctor. The grandmother's diabetes, polyarthralgia, and worry over the mental health problems of her adult daughter occupied most of the 45 minute consultation.

At several times during the office visit, other members of the APS team stepped into the room to drop off papers for signature or to pass along a brief message to Dra Paola. It was clear that the other members of the PHC team helped make sure that the two patients were up to date on immunizations and other routine services.

The caution

Much of what I saw in APS in Chile was admirable. The facilities were clean and had the necessary equipment. The APS teams were staffed by capable health care professionals who were caring, committed, and competent.



Group photo of some of the doctors of the University of Chile Dept of Family and Community Medicine. Dra Isabel Segovia, one of the very first family doctors in Chile and now chair at the University of Chile is seated to the right (wearing gray).

The teams appeared to function as they were designed – a variety of skills were available, everyone on the team was valued, and routine services were accomplished dependably. The result is that the basic health indicators for Chile are excellent given the amount of funds they have to invest on health care.

Yet, Chile could do better. The work of Starfield and others has shown that the two key aims, and assets, of primary care are the continuity relationship and comprehensiveness of services. In Chile, APS patients have access to information and management continuity (i.e., the APS units they attend record their information in the electronic record and the units follow standard protocols). However, APS patients do not have much personal continuity, as they are handed off from

one health worker to another. In conversations with several dozen family doctors, I could not find one who had stayed with the same APS team for more than 3-4 years. This is concerning since the full power of a continuity relationship appears on average to require 3-4 visits over 2-3 years.

I believe that the future of health care will require not only doing the routine dependably, as the Chilenos have done superbly, but also addressing the growing complexity and multiplicity of health problems that individual patients will increasingly present. Continuity relationships will be even more important as health professionals seek to leverage that trust to promote healthy behaviors, assure adherence to complex treatment regimens, and coordinate care across many clinicians.

As family doctors, most of us could not conceive of having a satisfying and successful practice without a team of colleagues to extend our reach and relationships with patients. Yet, teams are accountable only to team members. For example, it is impossible for a team to apologize meaningfully to an injured patient. That must be done by a person, or by several people, not by “the team.” Teams also consume enormous amounts of energy and time, as considerable effort is invested in keeping everyone on the team happy and effective.

Health care is a series of dyadic relationships. Ideally, all of the members of the health care team will individually have valued and trusted relationships with each patient they serve. Ultimately, there is a need for someone to make sense all the pieces of health information and connect those to the patient’s values and preferences, while understanding

the patient’s family and context. Around the world, we have found that the family doctor is best suited to play that role.

Why then do the APS units in Chile have a difficult time keeping family doctors on their teams? My answers are not what you might think. The usual response is that the specialty of Family Medicine is not well known or valued among health professionals or the public. While that might be true, it is not a relevant argument for the physician who has chosen Family Medicine and yet moves from one APS unit to another. Another response is that family doctors are not paid as well as other physicians. While that is also likely true, it does not explain why the family doctor moves from one low paying APS unit job to another.



Photo of a primary care team training session in Santiago.

I believe the problem is that the members of the APS team have defined their roles as a series of tasks, or things they do to patients, rather than as extending or enhancing the relationship that the family doctor has with every patient, regardless of problem. Even among the family doctors in Chile, there have been examples of this, such as recent efforts in some training programs to create a family doctor who specializes only in adults or only in children. The practical import of this is that the various members of the team view themselves as the exclusive purveyor of a limited set of services (“this is [only] what I do as a family doctor for children, a nurse, dentist, etc.”), and not as collaborators in helping the family doctor to establish and maintain a trusted healing relationship, and provide comprehensive services. This replicates within the APS team the same fragmentation of services one finds in specialist-dominated systems such as in my own country, the United States.

We can also see these trends in other countries that have lost some of their primary care luster as they shifted their focus to achieving biometric targets by delegating tasks to an ever more complex array of specialized professionals within the primary care team, such as occurred in the United Kingdom with its Quality Outcomes Framework. Over time, such shifts mean that more energy is devoted to improving team effectiveness and pursuing system-defined outcomes, to the detriment of a holistic approach to care and to the patient’s agenda. This fragmentation will eventually lead to more iatrogenic harms, worse outcomes that matter to patients, and lower patient satisfaction.

The challenge

Most health systems depend on doctors to make most of the resource allocation decisions (when and what to prescribe? when to send to hospital? when to refer for specialist consultation?). Yet, if other team members are allowed to choose their tasks only with an eye to what they enjoy doing most, then the family doctor is typically left with much of the drudgery of practice (writing letters for disability or absences, signing off on the care decisions of others), at the expense of the joy and meaning of the relationship with the patient, with its attendant negative impact on resource decisions.

Chile has created an APS system with enviable results. To improve further, the emphasis will need to shift more to the patient's agenda, rather than focusing primarily on system-defined outcomes, and to make explicit the primacy of the relationship between patient and family doctor, rather than indulging each team member's desire to do only self-defined work.

Chile is a beautiful country with a good primary health care system. It could have a great system if it improved the role, status, support, and payment of family doctors.

Professor Richard Roberts

President

World Organization of Family Doctors

FROM THE CEO'S DESK:

THE WONCA WEBSITE – TIME FOR A REVAMP?

The Wonca website www.GlobalFamilyDoctor.com (GFD) came under the exclusive financial and operational management of Wonca, in 2006.

An earlier three year agreement between Wonca and medi+World International on the management of the Wonca website ended, in May 2004, following somewhat bleak prospects of the website continuing, at the time, due to inadequate funding. Subsequently, at the Wonca Executive meeting in St Augustine, Florida, in November 2004, it was decided by Executive, after much discussion, that an attempt be made to keep the website going by committing funds from Wonca itself. At the same time, with the approval of the Orlando Wonca Council, the Wonca Secretariat set about seeking collaborations with and sponsorships from industries to support GFD.

To mark this change in management, a new homepage for GFD was introduced with top and side menus which allowed better site navigation. The website has been managed by Paradigm Multimedia with Mr Alex Westcott as the webmaster, these past six years (2006–2011).

At the Wonca Executive meeting in Chichen Itza, Mexico, just prior to the Cancun Wonca World Council meeting in 2010, it was decided that the time was ripe for a revamp of the Wonca website. This move to re-design the website came with the idea that perhaps some income from advertisements on the website would help with financing the site. This proposal was approved by the Wonca Executive committee, and the Wonca Secretariat subsequently started negotiating with a web-design and a website marketing company, in Australia.

Negotiations are currently ongoing to improve the aesthetics, navigation, functionality and scope of the website including an attractive and 'lively' homepage with the following features to be considered for inclusion:

Content: membership areas, global family doctor/secretariat news area, searchable content, listing of journals with standardised format.

Technically the new website should allow for:

- different levels of user (each level has the permissions of the level below)
- ability of customisation of 'skin'
- sale of sponsorship space
- e-commerce ability
- use with for mobile devices
- future linking to a number of social media sites such as Facebook, LinkedIn and twitter, which could drive traffic back to the site.
- a backup facility as well as rollback capabilities, so as to restore the website to an earlier state if something goes wrong with the site either due to posting, hardware failure or malicious attack.

In principle there should also be: language translation facilities or ability to post in native language with easy links to Google translate with specific

warnings on the translation; spam controller to reduce the level of possible spam postings in fora and blogs; designed and maintained with principles of search engine optimisation and usefulness to the target audience.

The Wonca President, President-Elect, Honorary Treasurer and CEO are currently in negotiations to try and secure a deal that will satisfy all these requirements at a price that Wonca can afford.

With this revamped website, there will also be the need to re-organise the web contents, resources and means by which the website receives news and information that will be attractive to members. This will require the cooperation and understanding of all Wonca member organisations and individual family doctors able to assist with this task to ensure that the visits to the website continue to grow and be possibly attractive as an advertising media for various varieties of industry.

Dr Alfred Loh

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FROM THE EDITOR:

THE PRESIDENT'S TRAVELS

The Wonca president, Richard Roberts, recently sent me his travel schedule. It might be some peoples' dream to spend a lot of time travelling the world and experiencing different cultures, but frankly, having received several of these travel schedules over the past year, I suspect our president's dream might be to have a quiet holiday with his wife and family away from the mobile phone. Not only does he travel world visiting Wonca's member organisations, he also seems in high demand in his own country.



Prof Richard Roberts receives Honorary Fellowship from president of the Royal Australian College of General Practitioners, Prof Claire Jackson

I have had many comments from readers enjoying Rich Roberts' reflections on what he has seen in other countries. Many enjoy his anecdotes of visits to the surgeries of ordinary GPs/family physicians, meetings with medical students and residents, and of course his analyses of a variety of health systems. This issue provides another fine example with Rich's recent visit to Chile providing the source of his reflections.

Rich Roberts visited my own country in October, to attend the annual conference of the Royal Australian College of General Practitioners (RACGP). As I had not been able to attend myself, I had almost forgotten Rich's visit when several weeks later, my friend and colleague, Marjorie, was still reflecting on Rich's plenary. He delivered the Stuart Patterson lecture at the opening ceremony: his lecture was titled *We need better science and new technologies: we need family medicine*.

For those who have never been lucky enough to hear our Wonca president speak, there is a link provided to an audio recording on the RACGP site: www.gp11.com.au

The PowerPoint presentation that goes with the lecture is included in the selection available on: <http://www.gp11.com.au/powerpoints.asp>

It was pleasing to see my college acknowledge Rich Roberts with the award of Honorary Fellowship. Of course, being Rich Roberts, he did not just make a lecture and receive an award; he took his usual interest in the day-to-day life of GPs in my country and found time to visit the practice of Dr Chris Hughes of Bridgewater, Tasmania.



Prof Roberts visits the Tasmanian practice of Dr Chris Hughes.

In this issue

While Rich Roberts was visiting my own country, I was enjoying the meeting of Wonca Europe, in Warsaw. A pictorial report on activities was included in the October issue of *Wonca News*. This issue features a conference report from Adam Windak, chair of the Warsaw host organising committee. There are also a number of reports from Wonca Europe and its networks, including stories about the *European Journal of General Practice*, the European General Practice Research Network (EGPRN) and the International Primary Care Respiratory Group (IPCRG).

Similarly, member organisations in the USA and Canada, have had their annual meetings and both organisations report on their new office bearers.

A number of member organisations are networking globally with the American Academy of Family Physicians reporting on its annual global health workshop; semFYC, the Spanish organisation reports on a meeting with Ibero-americana colleagues; and Wonca Asia Pacific leaders reporting on a recent visit to China.

It's also time to look ahead to conferences to be held in 2012, noting that there are December 2011

deadlines for abstracts, for both the European and Asia Pacific region conferences. Those contemplating abstract submission for the Wonca rural health conference in 2012 have a little longer to be organised. The Rajakumar young doctors' movement from the Asia Pacific region has announced its first pre-conference will be held in conjunction with the Asia Pacific Jeju conference.

People profiled in this issue are Wonca executive member-at-large, Dr Iona Heath, who recently gave the prestigious Harveian oration in the UK; Prof Manfred Maier, from Austria, who not only chairs Wonca's working party on ethical issues but is also the chair of the scientific committee for next year's Wonca Europe conference, to be held in Vienna; and Dr Julio Ceitlin from Argentina who was recently honoured by the College of Family Physicians of Canada.

Following this column is information relating to nominations for the Wonca 5-star doctor award. I urge everyone to consider their colleagues and nominate those who seem worthy of such an honour.

Finally, as the 2011 year ends, many of us will take holidays or take part in various religious festivals in the next couple of months. My best wishes for your happiness and safety wherever you are, and in whatever season or celebration you find yourself, between now and the next edition of *Wonca News*.

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NOMINATIONS FOR WONCA 5-STAR DOCTOR AWARDS

Nominations are called for the Wonca Award of Excellence in Health Care, otherwise known as “The 5-Star Doctor”.

This is an award to be conferred on physicians, who in the opinion of the Council have made a significant impact on the health of individual and communities, through personal contributions to health care and the profession. It is instituted in an attempt to increase the global development of Family Medicine, global networking and partnership. The award is preferably given to those who are still active in the field for which they are nominated. Nominations are not limited to Wonca members.

The award will be offered on a regional basis and on a global basis. The “Regional Awards” may be awarded on an annual basis and the “Global Award” will be awarded every third year (ie in the year of the Wonca World conference). The Global award will take the form of a crystal trophy and a certificate.

Suitably motivated and validated nominations for Regional Awards should be submitted to the Chairman of the Nominating and Awards Committee and to the appropriate Regional President for regional consideration. The Global Award will be chosen from the recipients of Regional Awards for that triennium.

The criteria for the Wonca Regional Five Star Doctor Award are:

1. A nominee must have the attributes of the 5-Star Doctor (see below).
2. A nominee should be a serving physician in mid-career who in

addition to providing regular service:

- provides innovative services to a community or special group
 - developed services where they were previously not available
 - supports colleagues in another region, country or college and also performs
 - academic work (teaching, research, quality assurance) of exceptional quality and relevance
3. A nominee can work outside his or her region, or create something that can be used outside his or her region or serve as a role model to other regions
4. The attributes of the 5-star doctor are:
- * **a care provider** who considers the patient as an integral part of a family and the community and provides a high standard of clinical care (excluding or diagnosing serious illness and injury, managing chronic disease and disability and provides personalised preventive care whilst building a trusting patient- doctor relationship
 - * **a decision maker**, who chooses which technologies to apply ethically and cost-effectively while enhancing the care that he or she provides;
 - * **a communicator**, who is able to promote healthy life-styles by emphatic explanation, thereby empowering individuals and groups to enhance and protect their health;
 - * **a community leader**, who has won the trust of the people among whom he or she works, who can reconcile individual and community health requirements and initiate action on behalf of the community;
 - * **a team member**, who can work harmoniously with individuals and organisations, within and outside the health care system, to meet his or her patients and community's needs.

Winners of the 2010 award, Dr Sonia Roache-Barker of Trinidad and Tobago and Prof Ruth Wilson of Canada, were featured in the December 2010 issue of *Wonca News*. To nominate, contact your Wonca region president, or for the global award, Prof Michael Kidd who is chair of the Wonca Nominating and Awards Committee.

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SPECIAL FEATURE

"DIVIDED WE FAIL": HARVEIAN ORATION 2011 – DR IONA HEATH

Wonca Executive member-at-large, Dr Iona Heath of the United Kingdom delivered the prestigious Harveian Oration, on 18 October 2011. The oration has been held most years since 1656 and Dr Heath is only the third woman and the second GP (the first female GP) to be granted this honour. Thankfully, since 1865, it has been delivered in English, not Latin. The following report is provided courtesy of the Royal College of Physicians. Full text of this oration and background information can be found at:

<http://www.rcplondon.ac.uk/sites/default/files/harveian-oration-2011-web-navigable.pdf>

The Harveian Oration

William Harvey, the eminent 17th Century physician who discovered the circulation of the blood, gave an indenture to the Royal College of Physicians, in 1656, for an annual dinner to encourage friendship between Fellows and Members of the College at which there should be an oration 'with an exhortation to the Fellows and Members of the said College to search and study out the secret of Nature by way of experiment'. The College continues the tradition by inviting a leading doctor or scientist to give the Oration on issues relating to his or her own field of work.

In this year's Harveian Oration, Dr Iona Heath, President of the Royal College of General Practitioners, explores the divisions within the medical profession, dualistic views of the human body, divisions within society and the implications of each

for the future of medicine. In an Oration brought to life with illuminating quotations from writers, poets and scientists, Dr Heath argues that we need to bridge those divisions to improve care for patients and create a fairer society. Key excerpts below:

The profession

Dr Heath argues that the historic division between general practitioners and specialists has been beneficial for both patients and the health service as a whole. GPs see the patient in the context of their wider life, and the referral process ensures specialists can concentrate on patients' specific diseases, ensuring a better outcome:

'General practitioners have learnt from experience the benefits, to both the individual and to society, of holding the border between subjective illness and the disease categories recognised by biomedical science; of confining people within those categories only when such labelling will be positively useful to them; and of deliberately minimising exposure to the harms of medical technology. In this way, general practice attempts to direct both the power and the rising costs of biomedical science where it can help rather than where it harms. Holding the border between illness and disease underwrites the cost-effectiveness of the health service to a far greater extent than gate-keeping at the point of referral.'

Dr Heath is worried about the recent introduction of competition and the effect it will have on the GP/specialist relationship:

'Medical specialists employed by acute hospital trusts are now working within a framework of incentives which provides 'Payment by Results' while medical generalists are being encouraged or coerced into undertaking commissioning, the intention of which is to keep patients away from costly hospital services. These policies are driving a wedge between specialists and generalists and making it more and more difficult for the two parts of the profession to work collaboratively in the interests of patients.'

The body

All patients experience illness and disease in a particular way – their own, and not as a standardised object. While doctors increasingly recognise this, *'the bureaucracy of healthcare seems more and more driven by the attractions of this (object) model and its attendant guidelines, quality indicators and payment for performance.'*

Dr Heath argues that the biomechanical approach to illness must be supplemented by an understanding of the patient's life and experiences, which are often key to the medical problems experienced:

'And science is beginning to show that there is also a medical relevance. Lives wound bodies and wounds leave deep bodily scars that never fully heal. They are caused by trauma including terrible accidents and injuries but they are also caused by abuse, misery, and humiliation, especially when these occur in early childhood. The patients we cannot cure, the ones who return again and again, have wounds and all too often we remain ignorant of their nature.'

Science is beginning to catch up with GPs' experience in this area, by showing us how a difficult life and continuous stress can bring on premature ageing by shortening telomeres – the parts of the chromosome that protect it from damage. Adverse experiences, particularly in childhood, also predict premature mortality and adult autoimmune disease. Now that the science is helping to explain the observations, how should the medical profession respond?

Society

Dr Heath explains how structural violence in society turns people into 'objects and things', and fosters social inequalities, exclusion, poverty, racism, and other situations that underpin health inequalities:

'As society becomes evermore economically polarised, health is systematically damaged by the structural violence this entails and yet governments still appear to believe that health inequality can be tackled in isolation from the socioeconomic inequality that drives it.'

'The evidence suggests that society should invest much more heavily in the early years of childhood and in providing opportunities for families to thrive. The present situation should be considered completely unacceptable: society both neglects and demonises vulnerable families, ignores the continuous process of damage that is undermining the health of poor children and then blames, and again demonises, health and social care professionals when children die.'

Instead of taking refuge in biotechnology, Dr Heath argues that doctors should lobby more strenuously to protect the vulnerable, minimise violence and abuse and promote a more equitable distribution of wealth, hope and opportunity within society:

'...medicine will never be a pure and simple place

but its constant interplay of opposites make space for courage, joy, creativity and freedom and the possibility of making the world a better place. However, if beyond this, we cannot bring these opposites together into a more coherent, and in the case of society a fairer, whole, we will remain divided and we will fail.'



Dr Iona Heath

PROFILE:
DR IONA HEATH
CBE FRCP PRCGP

Iona Heath worked as a general practitioner from 1975 until 2010 at the Caversham Group in Kentish Town in London, a deprived but wonderfully diverse inner city area. Over nearly 35 years she looked after three generations of many families.

She has been a nationally elected member of the Council of the Royal College of General Practitioners since 1989, and chaired the College's Committee on Medical Ethics from 1998 to 2004 and the International Committee from 2006 to 2009. She is currently President of the Royal College of General Practitioners, having been elected for a three-year term from November 2009.

From 1993 to 2001, she was an editorial adviser for the *British Medical Journal* and chaired the journal's ethics committee from 2004 to 2009. She was a member of the UK Human Genetics Commission from 2006 to 2009. She has been a member-at-large of the Wonca World executive and chair of the Membership Committee since 2007.

She writes regularly for the *British Medical Journal* and has contributed essays to many other medical journals across the world. She has been particularly interested to explore the nature of general practice, the importance of medical generalism, issues of justice and liberty in relation to healthcare, the corrosive influence of the medical industrial complex and the commercialisation of medicine, and the challenges posed by disease-mongering, the care of the dying, and violence within families. Her book entitled '*Matters of Life and Death*' was published by Radcliffe Publishing in 2007.

FEATURE STORIES: EUROPE IN FOCUS

17TH WONCA EUROPE CONFERENCE: REPORT FROM WARSAW

The annual Wonca Europe conference, in 2011, took place in Warsaw, Poland from September 8-11. Under the theme *Family Medicine – Practice, Science and Art*, a rich and diverse scientific program was developed. It consisted of preconference events, key-note speeches, workshops, oral and poster presentations well as many other additional meetings.

Abstracts for the conference were submitted until March 7, 2011. The process of submission and evaluation of the abstracts was done on-line. All the abstracts were peer-reviewed by members of Scientific Committee, International Advisory Board and recruited experts. 856 abstracts were submitted: 282 for oral presentation, 495 for posters and 52 for workshops. After the evaluation process, 27 of them were rejected.

The most abstracts were submitted by authors from Spain (n=222), Portugal (n=99), Turkey (n=61), Serbia and Montenegro (n=60). 95% of the abstracts came from authors from 28 countries - mostly from Europe, but also Turkey, South Korea, Canada, Brazil, Australia and Hong Kong.

The final scientific programme consisted of:

- five key-note speeches
- 91 workshops
- 48 sessions with 270 oral presentations
- 483 posters
- Preconference events – Vasco da Gama Movement and European Society for Primary Care Gastroenterology
- two satellite symposia
- several meetings of special interest groups



Prof Maciej Godycki-Cwirko, president of the College of Family Physicians in Poland, with Prof Adam Windak, Chair of the Scientific Committee looking on at the opening ceremony.

Key-note speeches

All key-note speeches referred to the Conference leading theme: *Family Medicine - Practice, Science, Art*. The following lectures were given:

- *The state of the art of primary care in Europe* by Dr Dionne Sofia Kringos (The Netherlands) and Dr Wienke Boerma (The Netherlands)
- *The Science of Family Medicine* by Prof Nigel Mathers (UK)
- *European collaboration in primary care research* by Prof Theo Verheij (The Netherlands)
- *Economic Crisis, Aging Populations and the Practice of Family Medicine* by Dr Mukesh Chawla (USA)
- *Prevention of CVD disease – from dreams to reality* by Dr Bjorn Gjelsvik (Norway)

Workshops

Of the 91 workshops scheduled for the conference, 52 of them were submitted by individual participants, while the remaining 39 by Wonca Europe network organisations or special interest groups (see table 1). The most common topics for the workshop sessions workshop sessions were: education in family medicine/general practice (14); financing and organisation, health promotion and disease prevention (six each); cross-cultural medicine / gender issues, mental health, philosophy and ethics (three each).

Table 1. Workshops by Wonca Europe network organisations and special interest groups

* one joint workshop, † one joint workshop

Wonca Networks	No. of workshops
EGPRN*	5
EQuIP	5
EURACT	5
VdGM †	5
IPCRG	4
EURIPA †	3
EUOPREV	3
WWPWF	3
EPCCS	2
PCDE*	2
ESPCG	1
EFPC	1

Oral and Poster Presentations

During Conference total number of 270 oral presentations was given in 26 sessions. The numbers of presentations of the commonest abstracts' themes were: health promotion and disease prevention (n=36), education in family medicine/ general practice (n=34), cardiovascular diseases (n=21), infectious diseases (n=16), quality improvement (n=16), public health issues (n=13), mental health (n=12), and diabetes (n=11).

The poster presentations were divided into two sessions, one per conference day. The most common topics covered by the 483 posters were: cardiovascular diseases (n=65), diabetes (n=49), health promotion and disease prevention (n=44).

Accompanying events

In addition to main scientific program there were some accompanying events. Two pre-conferences took place before opening ceremony of the 17th Wonca Europe Conference.

The Vasco da Gama Movement (VdGM) preconference was held on September 7-8, 2011. This year's discussion theme was *Primary Care, Family Medicine and Global Health..* Preconference participants had the chance to get acquainted with the activities of VdGM with the aim to stimulate young GPs' enthusiasm in maintaining the goals of a high quality family medicine in their countries as well as throughout Europe, working along the following lines "think globally, act locally".

The other Preconference was organized by European Society for Primary Care Gastroenterology (ESPCG) and it took place on September 8. The aim of this course was to provide a high quality postgraduate CME program on gastroenterology in primary care. This course was intended for primary care physicians from European countries, academic and non-academic, who are involved in teaching and research in primary care medicine in their country.

There were also two satellite symposia. The first, *Family Doctors Manage Non-Communicable Diseases! New Emphasis on Health Care for the EU* was hosted by Wonca president, Prof Rich Roberts. Speakers included Prof Jean Bousquet, Prof Boleslaw Samolinski, and Prof Gabriel Ivbijaro. This satellite symposium addressed the role of family doctors and general practitioners in the management of non-communicable disease in the European Union. Topics include *Improving Health Care in the EU during the Polish EU Presidency, The*



Young doctors of the Vasco da Gama movement at the pre-conference

Collaboration of Polish Medical and Health Ministry Leaders in the WHO's GARD Initiative: A Case Study of Pediatric Respiratory Diseases and The Launch of Wonca's Textbook on Primary Care Management of Mental Illnesses: A Companion to Mental Health in Primary Care.

The other satellite symposium was *Smoking Cessation & Cease Smoking Today (CS2day)*. This participatory session examined community and clinician needs for those promoting smoking cessation among their patients. It was a closed meeting by invitation only.

Other special meetings held during the conference included Wonca Europe open board meeting, Wonca Working Party on Women in Family Medicine meeting, the Dutch College of General Practitioners' meeting, the Vasco da Gama Movement exchange meeting and the Austrian Society of General Practice meeting.

Attendees

Over three thousand registered participants from all over the world attended Wonca Europe Conference, in Warsaw. The largest number of participants was from Spain, The Netherlands, Croatia, Portugal, Greece, and Turkey (all with over 100 registrants). People came from all regions of Wonca, with good representation from the Asia-Pacific region (especially Philippines, South Korea, Thailand, Australia). From other regions, registrants came from Canada, USA, Brazil, Nigeria, South Africa and Lebanon.

The organisation of Wonca Europe 2011 conference, in Warsaw, was an honour and big challenge to the College of Family Physicians in Poland. Dozens of colleagues worked very hard for several years to make it a big success. We hope that the three thousand family doctors, coming from all over the world had really good time in Poland. We believe that they benefited from the scientific programme of the conference, as well enjoyed beauty of the country, its culture and friendship of people. The favorable opinions of the participants and Wonca Europe leaders are a source of tremendous satisfaction for all of us. We all have a feeling of a good job done and relief, but we still hope to host another Wonca gathering in future. A world conference? Who knows?

Prof Adam Windak

Vice-President of the College of Family Physicians in Poland and Chair of the Scientific Committee of 17th Wonca Europe Conference 2011

Editor's note: a photographic report of the Warsaw conference was published in the October issue of Wonca News. The official website of the conference is still open and contains a new photo gallery.

<http://woncaeurope2011.org/gallery.php>

WONCA EUROPE EXECUTIVE BOARD AND COUNCIL REPORT

This item is provided courtesy of the European Journal of General Practice.

Warsaw: a musical conference

The participants of the 2011 Wonca Europe Conference in Warsaw, will certainly remember the different and exciting musical contributions. Furthermore, there was enough scientific content to take home messages for reflection or action. With around 3000 participants, our Polish colleagues were content and can look back at a job well done.

Wonca Europe Executive Board and Council



Head table at the Wonca Europe Board meeting in Warsaw

Just before the start of the conference, the Wonca Europe Executive Board (EB) and Wonca Europe Council had their regular meetings to discuss and decide on a number of issues.

EJGP

The EB and Council were pleased with the ongoing progress of the European Journal of General Practice (EJGP). There is a continuous submission of new manuscripts, the review process is in order and the journal appears four times a year, on time. On top of that, the editor-in chief Jelle Stoffers announced that the EJGP will be included in the prestigious 'Science Citation Index expanded', making the journal even more interesting for researchers. Another challenge is making the EJGP available on line to all family physicians in Europe. Although this is a commendable goal, it will not be as easy to realise. As always, we will follow a step-by-step approach.

Liaison with UEMO and EFPC

The Council was further informed about the ongoing liaison of Wonca Europe with UEMO (European Union of General Practitioners) and the EFPC (European Forum of Primary Care). The three organizations have several common interests, and have been meeting to figure out the best way of working together.

Special interest groups

The Council reviewed the reports of the Wonca Europe Special Interest Groups (WESIGs) at the end of their first term of three years. The WESIGs have proven to be very instrumental in establishing good relations to several specialist organisations, and have contributed to a number of well-balanced guidelines. Council voted for a continuation of the agreements of collaboration.

New European Definition of general practice/family medicine

During the Malaga Council meeting it was proposed to include "patient empowerment" and "continuous quality improvement" as minor revisions in the new European Definition of General Practice/ Family Medicine. Ernesto Mola, leader of the working group, presented the revised version, which was accepted by Council. The revised version is available as PDF file on the Wonca Europe website. During the revision process, comments and suggestions were made for other parts of the definition. The EB will look into the necessity for a major revision.

Future composition of Executive Board and Council

Council also spent time in small groups to discuss the composition of the Executive Board and Council in the future. When Wonca Europe was formed, the three core networks (Euract, EGPRN, and EQuIP) were given a seat each in the EB. Wonca Europe has developed and now has more networks and special interest groups. Therefore, the question to the delegates was to discuss the future composition and come up with suggestions. They did, but there is no clear direction from the different groups. The EB will come up with a proposal taking into account the suggestions made.



(l to r) Wonca Europe president, Dr Tony Mathie; secretariat, Ms Barbara Toplek; and Wonca Europe secretary, Prof Job Metssemakers.

Website and Agenda

<http://www.woncaeurope.org>

The Wonca Europe website now has a link to a calendar of all national conferences in the member countries, facilitating cross border visits and hopefully further collaboration. It can also support countries that still are developing family medicine.

Just a note for your agenda: Wonca Europe 2012 will be in Vienna 4-7 July. Without doubt, we will have plenty of music again.

Prof Job Metssemakers
Secretary Wonca Europe

WONCA EUROPE - JOURNAL RECEIVES 'IMPACT FACTOR' IN 2012



Since June 2009, A/Prof Jelle Stoffers has been the editor-in-chief of the *European Journal of General Practice (EJGP)*. This is the official journal of the European Society of General Practice and Family Medicine (Wonca Europe).



A/Prof Jelle Stoffers,
editor-in-chief of the EJGP

The aim of the journal is to encourage scientific research in general practice/ family medicine and primary health care in Europe; to support education and stimulate debate relevant for the development of the discipline in Europe; and to facilitate the communication between the members of Wonca Europe and other parties involved in research and teaching. During the last two years, Jelle Stoffers and his international team of editors have worked hard to guarantee continuity and timely publication of the EJGP.

Recently, Jelle Stoffers - family physician and associate professor at Maastricht University - received the exciting news that the EJGP has been accepted for inclusion in the Science Citation Index Expanded, beginning with the first issue of 2009. Consequently, the EJGP will be listed with an 'Impact Factor' in the *2011 Journal Citation Reports*, in June 2012. EJGP will be the fourteenth journal in the new subject category 'Primary health care'.

Now that an important barrier for submitting research articles to the journal is levelled, Jelle Stoffers expects to publish papers of higher quality and more relevance, and to attract a wider readership. This opens a new perspective for the EJGP: to become a leading journal in the category 'Primary Health Care'.

"It's my dream that every GP/ family doctor in Europe will read our journal", Jelle Stoffers says.

Members of the EGPRN already have free access to the online version of the EJGP. "I like what the

Scandinavians do”, Jelle continues. “Their Nordic Federation of General Practice arranges free online access to the *Scandinavian Journal of Primary Health Care* for everyone!”.

Now it is up to everyone else who is committed to the case of family medicine in Europe, authors as well as readers of scientific publications, to show that EJGP can live up to its new status. The editorial team counts on a continued flow of good manuscripts on a broad variety of topics relevant for the development of primary care (<http://mc.manuscriptcentral.com/ejgp>).

“We are an enthusiastic team of editors, who will continue to give our authors the highest possible service in efficient manuscript flow, constructive feedback and guidance on writing. We want to offer European primary care a lively scientific journal that is representative for the creativity in this part of the world”, Jelle Stoffers says.

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EUROPEAN DEFINITION OF GENERAL PRACTICE: 2011 REVISION

At the meeting of 2010, in Malaga, the Wonca Europe Council decided to appoint a small Commission, made up of people from different countries and networks, to make a minor revision of the European Definition of General Practice in order to include two new concepts: patient empowerment and continuous quality improvement. Following a work plan agreed upon with the Executive

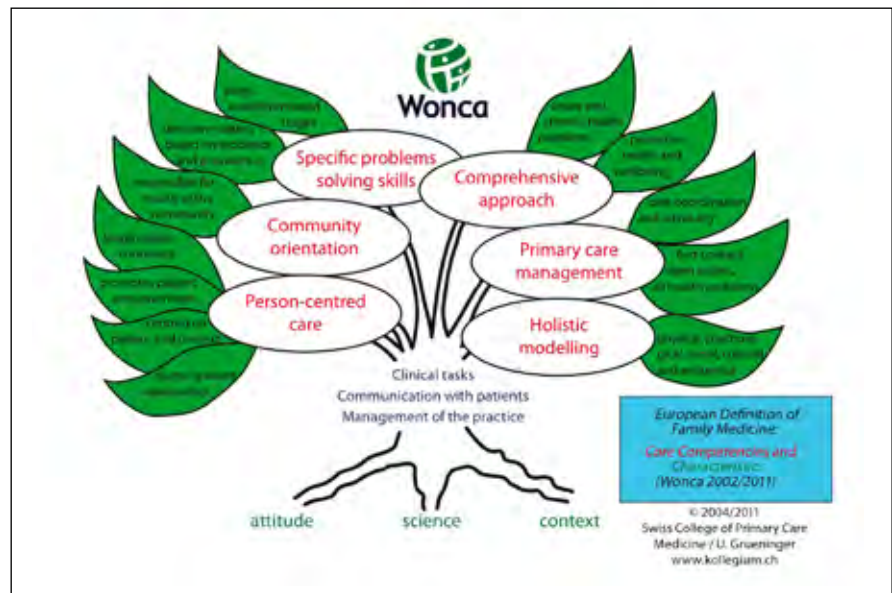
Board, the commission examined two systematic proposals, based on a wide range of background knowledge, concerning the inclusion into the definitions of patient empowerment and of continuous quality improvement.

At the end, an amended version of the definitions (based on the members' opinions) was written down and sent to the Colleges, in July 2011, to allow for an informed discussion at the subsequent European Council meeting, in Warsaw, where it was approved.

The minor revision was aimed to update the definitions and make them more adherent to the reality of general practice and of primary care and to the needs created by social and epidemiological changes.

Dr Ernesto Mola and Dr Tina Eriksson give the above explanation as part of an introduction to the 2011 revision. The final document gives the following definition of general practice/ family medicine but also describes the core competencies of general practitioners and the characteristics of the specialty.

Core competency tree



Definition of the Specialty of General Practice / Family Medicine

General practitioners/family doctors are specialist physicians trained in the principles of the discipline. They are personal doctors, primarily responsible for the provision of comprehensive and continuing care to every individual seeking medical care irrespective of age, sex and illness. They care for individuals in the context of their family, their community, and their culture, always respecting the autonomy of their patients. They recognise they will also have a professional responsibility to their community. In negotiating management plans with their patients they integrate physical, psychological, social, cultural and existential factors, utilising the knowledge and trust engendered by repeated contacts. General practitioners/family physicians exercise their professional role by promoting health, preventing disease

and providing cure, care, or palliation and promoting patient empowerment and self-management. This is done either directly or through the services of others according to health needs and the resources available within the community they serve, assisting patients where necessary in accessing these services. They must take the responsibility for developing and maintaining their skills, personal balance and values as a basis for effective and safe patient care. Like other medical professionals, they must take responsibility for continuously monitoring, maintaining and if necessary improving clinical aspects, services and organisation, patient safety and patient satisfaction of the care they provide.

The complete document can be viewed on the websites of both Wonca Europe and Wonca world.

www.woncaeurope.org or www.globalfamilydoctor.com

IPCRG AND WONCA EUROPE AGREEMENT OF COLLABORATION 2011-14

The International Primary Care Respiratory Group (IPCRG)'s collaboration with other family physicians' societies continues growing. During the last Wonca Europe conference, held in Warsaw, during September, IPCRG president Miguel Román and Wonca Europe president Tony Mathie signed an agreement of collaboration for the next three years. This agreement establishes a formal relationship between both organisations, after years of collaboration in defence of the role of primary care in the management of chronic conditions. IPCRG will represent Wonca Europe, when required, and will be its liaison with secondary care clinical respiratory societies. By this agreement, IPCRG will also deliver key-note or state-of-the-art lectures and lead workshops at every Wonca Europe annual meeting.

IPCRG meetings in Warsaw

IPCRG developed a full day education meeting in respiratory chronic conditions, which was delivered during the last Wonca Europe conference, in Warsaw. Attendance to our four workshops during the day has exceeded expectations, reaching audiences of more than 70 people, some of them standing at the back of the room. The level of participation and interaction of the attendees was high and it made the sessions very interesting and refreshing.

The first session in the morning was chaired by Dr Catalina Patainescu, from Romania, and covered the most common respiratory problems in children. The increase of tuberculosis and other infectious respiratory diseases,

such as pneumonia, was clearly explained by Dr Tsiglianni from Crete. Prof Jim Reid, from New Zealand, delivered a clear and practical session on the multiple aetiology of cough during childhood and the less common causes, which we should never forget, when assessing a chronic cough. Wheezing was the last issue covered in this session by Dr Hoeghsen, from Oslo, and he reminded us of the confusion about the term in different countries and that "not everything that wheezes is asthma".



At the IPCRG seminar were Prof Jim Reid of New Zealand, Dr Jana Bendova of Slovakia, and IPCRG president, Dr Miguel Román Rodríguez of Spain

During the second session we tried to explain to primary care doctors what the meaning of asthma control is, how to measure it and what to do when we detect poor asthma control in our patients. Dr Miguel Román, from Spain, ended this session with a real-life case study trying to clarify how control can be assessed and measures to improve it be taken, in a busy seven minute primary care consultation.

Early detection of COPD was the issue for the third workshop. Though held in the "difficult" time to maintain concentration after lunch time, it was a successful workshop where the chairman encouraged people from many different countries to participate and to explain their country's situation about spirometry, early detection and screening for COPD, regulations about tobacco and the important role of primary care doctors and nurses in fighting the smoking epidemic and helping people to quit. Although there are many different situations across countries, the barriers seem to be less important for good management of COPD and its main cause, tobacco smoking.

The final session generated great interest and crowded room, possibly because it covered a very important and common chronic condition that is faced daily in our consultations: allergies. Not only respiratory,

but gastrointestinal and skin allergies were briefly presented during the session. The participation of the audience again made this session very useful in understanding how allergic conditions are managed in different settings and with diverse resources; and how we could promote a “sane” relation with secondary care specialists.

All presentations will be available from our website.

The IPCRG 6th world conference that will be held in Edinburgh, in April 2011, was also presented. Opinion sheets and other written materials were given to the audience and at the IPCRG stand. Many contacts were made and new associate members from different countries will join us from this moment. Welcome to IPCRG!

Miguel Román Rodríguez
IPCRG President
miguelroman@ibsalut.caib.es
www.theipcr.org

THE EUROPEAN GENERAL PRACTICE RESEARCH NETWORK EXPLAINED

www.egprn.org

The European General Practice Research Network (EGPRN) is the research network of Wonca Europe. The organisation promotes and develops research in general practice/family medicine in Europe. Its members are keen researchers in the field, from academics to clinicians who want to better understand what they do and how they can do it better. The organisation meets twice a year for three days in different European countries, and its meetings are always exciting, dealing with a different theme every time! The group also has a significant presence at Wonca Europe conferences.

Aims and objectives

Its main aims are to promote and stimulate research in general practice and primary care, to initiate and coordinate multinational research projects, to exchange research experiences and by doing so to develop a valid international base for general practice.

These aims are pursued a) by organisation of international workshops, b) by learning from other research experiences in Europe by international contacts, discussion and exchange of information, c) by stimulating research in and for general practice in Europe through the development of common definitions and relevant research and conducting international research projects.

The organisation

The EGPRN is an organisation of general practitioners and health professionals with an interest in research in general practice. The EGPRN originated in 1974 as a result of meetings between general practice researchers from countries bordering the North Sea. There are National Representatives from more than 30 European countries. The EGPRN is governed by an executive board of eight persons and a general council consisting of one national representative from each of the European countries participating.



Promoting EGPRN in Warsaw were secretariat Mrs Hanni Prick with honorary secretary Dr Jean Karl Soler of Malta, and executive board member, Dr Ferdinando Petrazzuoli of Italy.

Membership

Anyone interested in general practice research can become a member of the EGPRN by paying a membership fee (300 for three years). Membership can be obtained online. There are reduced membership fees for people from countries with > 30% lower GDP/capita as compared to the European average.

Institutional membership is also available and the member organisation can send two participants as ‘member’ to each EGPRN conference. The head (or another senior staff member) of the member organisation will join the EGPRN Advisory Board.

As well as the benefits of having the possibility to exchange research ideas in an international audience, EGPRN members are eligible for reduced subscription for a number of journals including Family Practice and the *European Journal of General Practice*. The EGPRN has a published strategy on research, offering twice a year, the possibility to apply for funds.

Meetings and activities

The EGPRN meets twice a year, generally in the second full weekend in May and the third full weekend in October, for three-and-a-half days of pre-conference workshops, scientific papers, including sessions of freestanding papers as well as papers about a pre-determined conference theme and posters. These meetings are truly workshops, with around 100 people attending. During these meetings proposals for research, work in preparation and unpublished studies can be presented in an atmosphere which, whilst begin constructively critical, is also friendly and safe. It is not necessary to be a member to visit these meetings.

Abstracts of the meetings are published twice a year in the indexed *European Journal of General Practice*.

The EGPRN organises international research courses in general practice. These week-long courses are designed to promote knowledge about research methods amongst general practitioners. Since 1984, there have been courses in England, Denmark, Italy, Spain, Ireland, Portugal, Sweden, Malta and Poland.

The EGPRN has conducted several European collaborative studies, often with financial support of the European Community (COMAC-HSR), such as the European Interface Study, the European Referral Study, the Forum Project, the International Study of Burnout and the Eurobstacle Study.

Contact

The central administrative office of the EGPRN is attached to the department of General Practice, Maastricht University in Maastricht - The Netherlands. Please contact Mrs Hanny Prick for more information.

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NEWS FROM EQUIP TO WONCA WORLD

Practice Accreditation (Practice Accreditation) highlighted

The European Society for Quality and Safety in Family Practice (EQuIP) meeting November, 3-5 2011 in Zagreb, Croatia focused on a single theme – accreditation in general practice/ family medicine; and this theme was

chosen in close collaboration with the hosting country. The meeting was arranged by Croatian EQuIP members Zlata Ozvacic and Venija Cerovecki and supported by the A Stampar School of Social Medicine.

Data collection prior to the meeting

One of the new features of the meeting was that prior to the meeting a web survey on the state of Practice Accreditation in the EQuIP member countries was performed. We received answers from 25 delegates, in 21 countries.

We learned that general practice colleges in The Netherlands, Estonia, Czech Republic and the United Kingdom (UK) are organising Practice Accreditation systems in their countries. In Poland, Portugal, Switzerland, and Turkey, and soon in Croatia and Denmark, various central health authorities are taking the lead in Practice Accreditation systems. The European Practice Assessment is used in Austria, Belgium and Germany and as a part of the college initiated systems in The Netherlands, UK and the Czech Republic. In several countries ISO certification is in use; among these are Finland and Sweden. European Foundation of Quality Management (EFQM) are used in other countries such as Spain and Finland. In conclusion, there is a wide variety of Practice Accreditation systems in use, in several countries more than one system is in use at the same time, and there seem to be a great need of more knowledge on the pros and cons of the different systems.

Opening of the meeting to locals

The meeting had yet another new feature: an open part of the meeting to local GPs and administrators of Quality and Safety, where EQuIP delegates offered their expertise and experience to the hosting country on the chosen aspect of quality. Croatia is planning to launch a national accreditation system organised by the Croatian Ministry of Health.

The open part of the meeting was a success, with a range of interesting presentations of European Practice Accreditation systems. Prof Helen Lester presented the newly developed system in the UK; Rob Dijkstra presented the system developed by the Dutch College that after several years have accredited a large proportion of the GPs in the Netherlands. Moreover, Sara Willms presented the latest developments and research results of the European Practice Assessment (EPractice Accreditation) that was initiated in EQuIP from 2001-2004 and later spread by the TOPpractice AccreditationS collaboration.



Equip group at the meeting in Croatia

Katrin Martinson from Estonia presented yet another accreditation system developed by a European college, and last but not least Venija Cerovecki presented the Croatian accreditation system initiated and organised by the Croatian Ministry of health.

Visit the EQuIP website and see videos, PowerPoints and more of the presentations mentioned above.

Later, a panel discussion highlighted variation in Practice Accreditation structures. Helen Lester gave examples of top down systems like the one in Croatia and practice level up through college (UK); emphasis on the importance of achieving buy-in at GP and practice level. Rob Dijkstra made a SWOT analysis (strengths, weaknesses, opportunities and threats) of the systems presented.

Sara Willms was impressed with levels of development and highlighted importance of paying attention to data management, and to focus more on quality of the system rather on the quantity of data collected.

The key points may be summarised as follows:

- keep practice accreditation systems simple, especially at the start
- make broad measurements
- involve patients and staff
- implement change on the basis of measurement, best done within practice meetings, practice visit or some social context rather than online
- good practice accreditation needs internal and external motivators

We are planning one or more publications on the subject of Practice Accreditation in the near future – keep updated at the EQuIP website. You may also sign up at EQuIP's Facebook and LinkedIn groups.

On-line content

www.equip.ch

Podcasts available online include:
 Helen Lester on *European accreditation schemes -UK*;
 Rob Dijkstra, *European accreditation schemes – the Netherlands*;
 Venija Cerovecki Nekic, *plan and structure of accreditation process in family medicine in Croatia*;
 Hrvoje Tiljak, *Accreditation in Croatian family medicine - ideas and lessons from past experience*

Webcasts are available on accreditation in UK and the Netherlands

EQuIP on the way to be an open network

Yet another step was taken in Zagreb to open EQuIP to individual and organisational membership. As it is, delegates are appointed by colleges and other Wonca Europe member organisations – a maximum of two per country. At the EQuIP meeting in April, in Copenhagen, the first steps were taken, and at the recent meeting in Zagreb a work group on the organisational issues was formed. The final decision to open EQuIP for external membership may be taken in Stockholm, in April 2012. So if you fancy joining us - keep an eye at our website.

Tina Eriksson,
 President of EQuIP

WONCA REGIONAL NEWS

AP REGION EXECUTIVES VISIT CHINA

The Chinese government is currently discussing ways of transforming healthcare, especially in standardising both education and practice. The China General Practice Society of the China Medical Association held their annual general meeting and scientific meeting from September 15-17, 2011. There was a pre-conference workshop arranged on September 14, 2011 and the topics for the workshop and the scientific meeting were mainly to discuss the general practice involvement in the transformation.

President and vice president of the Wonca Asia Pacific region, Drs Donald Li and Daniel Thuraiappah, respectively, attended these events primarily to establish contacts with the new China General Practice Society leaders and secondarily to learn about the Chinese health system and general practice.

Prof Gu was already known to us, but the new chairman of the GP Society is Prof Zhu.



Prof Zhu with the memento presented by Wonca Asia Pacific leaders Drs Daniel Thuraiappah, vice president (centre), and Donald Li, president (right)

The workshop was arranged in Shenzhen by the Post Graduate Medical Centre which is currently headed by Dr Xia Jungjie and on the next day, the Scientific Conference was held in Xian, which is nearly three hours away in the north.

Shenzhen workshop

The workshop in Shenzhen was held with the post graduate GPs currently in their residency program. The topic of the workshop was *General Practice Quality Improvement Program* 全科医生服务质量提升管理培训课程. There was a lively discussion about facilities in the community health centres. There is great variation between new and older centres.



Dr Daniel Thuraiappah (sixth from left) with the group of QIP trainees. The banner describes the welcome and workshop

More than 95% of healthcare is delivered through public facilities, like community clinics, which do not provide as many services as community health centres, where some of them have inpatient care for the elderly. There is also much variation in the standard of care and therefore this workshop provided an avenue to discuss indicators for care especially those which were 'costless' and part of the routine clinical examination, and those indicators which require a laboratory or certain equipment for investigation and may require payment.

Shenzhen is a Special Administrative Region where a co-payment system has been implemented and all employees contribute to a health fund. There is also a voluntary private insurance system in place for selective care.

The joint practice of traditional pharmaceuticals with western medicine is common in all public facilities, including the use of acupuncture and chiropractic. All practitioners are salaried but are rewarded annually for good practice, with conference attendances and other forms of CME. While Shenzhen may enjoy a fairly satisfactory healthcare system, this may not be universal in all parts of China.

Xian scientific meeting

The scientific meeting started off with a welcome speech by the Deputy Minister for Health, Chen Zhu, 陈竺部长, who stood in for the Minister. This was

followed by the Director General of Health, Huai-Jin 秦怀金司长 who outlined the guidelines of transformation of healthcare *Guidelines and Interpretation of State Council Health Care Policy* 解读国务院, 指导意见.

Then followed Wonca Asia Pacific region president Dr Donald Li 李国栋医生: *Evolution of general medical services* 演变中的全科医学服务. His presentation was informative and therefore should be published in full because it outlined the past which was a pathway for the future in China. Dr Donald Li presented the GP Society of China with a memento from Wonca Asia Pacific Region.

The President Fan Jianping 樊建平院长 spoke on *Promotion of low cost health care and medicine network* 推动全民低成本健康海云工程筑牢医疗网底.



Dr Daniel Thuraiappah with Dr Xia Jungjie (seated) and Dr Wang Su and Mr Chin Yew Meng (standing)

The afternoon proved very interesting as there were three concurrent sessions before and after coffee breaks discussing the following issues.

- *The establishment of general practitioners with a road map for the pilot system.*
建立全科医生制度的路线图与试点
- *Standardized training for general practitioners.*
全科医生规范化培训
- *Community chronic disease management.*
社区慢性病管理
- *Building GP services platform.*
搭建全科医生服务平台
- *GP training and retraining.* 全科医生转岗培训
- *Community health management.* 社区人群健康管理

All the sessions were hotly debated and there was no shortage of ideas and personal agendas. Most spoke from personal experiences and debated their own wish-lists but with expert chairing and camaraderie. The evening ended with a feast and exchange of gifts.

The next morning continued with the following concurrent sessions:

- *General medicine and community health service management* 全科医疗与社区卫生服务管理
- *Training of rural health practitioners in general medicine.* 农村卫生人员全科医学培训与实践
- *Building GP services platform.*
搭建全科医生服务平台
- *Clinical practice and general practitioner services.*
全科医生临床思维与服务
- *Community Health Service and Community Care team building.* 社区卫生服务团队建设与社区护理
- *General medical informatics and technical equipment applications.* 全科医疗信息平台及适宜技术设备

In the afternoon I gave a presentation on *Malaysian GP training* 马来西亚的全科医生培训. This was followed by Prof Gu who spoke on *GP system to expand the implementation of primary health care.* Representatives of each group also introduced exciting content.

The conference topics were current and invited many new ideas for healthcare compared to the topics when I attended the inauguration of the GP Society in 1989 in Beijing. The Chinese government faces an uphill task of standardising care throughout China, but it is encouraging to note that many of the cities enjoy good primary care. Statistics show that all indices of health have improved in the last 10 years by more than 30%.¹ Beijing's MMR has reached western standards.²

¹. <http://english.peopledaily.com.cn/90882/7601833.html>

². <http://www.womenofchina.cn/html/report/77840-1.htm>

Datuk Assoc Prof (Adj) Daniel M Thuraiappah
Vice President, Wonca Asia Pacific Region.

DECEMBER 2011 DEADLINE FOR EUROPE AND AP CONFERENCE ABSTRACTS

Wonca's Asia-Pacific Jeju 2012 and Wonca Europe Vienna 2012 conferences both have a coming deadline for regular abstract submission, in December 2011. Prospective presenters are urged to consult the websites of these conferences for further information about the online submission processes.

Wonca Asia Pacific Jeju 2012 at a glance

Dates: May 24-27, 2012

Venue: Jeju, Korea

Theme: Clinical excellence in family medicine: evidence-based approach in primary care

Deadline abstract submission: December 30, 2011

Early bird registration closes: December 30, 2011

Pre-registration February 29, 2012

Web: <http://www.woncaap2012.org>

E-mail: admin@woncaap2012.org

Wonca Europe Vienna 2012 at a glance

Dates: July 4-7, 2012

Venue: Vienna, Austria

Theme: The art and science of general practice

Deadline regular abstract submission:

December 15, 2011

Deadline "last week results" submission:

March 15, 2012

Early bird registration closes: February 29, 2012

Hotel reservation: April 02, 2012

Online registration: June 15, 2012

Web: <http://woncaeurope2012.org/>

WONCA ASIA PACIFIC JEJU 2012**A message from the Wonca Asia Pacific region president.**

On behalf of Wonca Asia Pacific Region I wish to congratulate the Korean Academy of Family Medicine (KAFM) for bringing the Wonca Asia Pacific Conference to Jeju in Korea in 2012.

The Conference theme chosen by KAFM - *Evidence-Based Approach to Primary Care* - is a most appropriate one especially when Family Physicians take up a key position in the primary healthcare system. To gain the trust of patients, administrators, policy makers, we must provide evidence that support the best practices and holistic care delivered in primary medical care through the practice of family medicine. I am sure we will be learning a lot in the conference.

I urge everyone from the region, representing member organizations and international experts to submit papers, make presentations, and participate in workshops and exhibit posters. This will enrich the program for every delegate. Of course you are also most welcome to simply come and renew acquaintances, participate and relax while you learn and enjoy the Korean hospitality!

I wish to extend a personal welcome to each delegate and encourage you to plan ahead and come to Jeju in 2012!!

Yours truly,
Dr Donald Li



Dr Donald Li, Asia Pacific region president

Wonca leaders head the program

Wonca leaders are set to play a significant role in the conference program. Wonca president, Prof Rich Roberts, is to deliver a plenary entitled *A world of family doctors: improving health, serving communities*. Wonca president-elect, Prof Michael Kidd, is to deliver a plenary called *What is the meaning of clinical practice guidelines in primary care*.

Abstract Submission Deadline: Dec 30, 2011

The WONCA Jeju 2012 Scientific Program Committee cordially invites you to submit abstracts for free paper, poster and video presentation. All abstracts will be reviewed by the scientific program committee and assigned to the appropriate session for oral and poster presentations.

Abstracts should be submitted online and in English. A broad range of topics covering clinical practice, education, research and other aspects of primary care are suggested.

Visa information for Jeju

For those who travel directly to Jeju, not connecting at the Korean cities of Incheon or Seoul, visitors are allowed to stay without a visa for up to 30 days, except for those who are travelling from the following countries: Afghanistan, Cuba, Ghana, Iran, Iraq, Kosovo, Nigeria, Macedonia, Palestine, Sudan, and Syria. A visa must be obtained by those who travel from China and connect at Incheon or Seoul.

In summary for most people, if you are arriving directly to Jeju, no visa is required. For more information see the conference website.

<http://www.woncaap2012.org/venue5.htm>

INAUGURAL RAJAKUMAR MOVEMENT PRE-CONFERENCE IN JEJU

In conjunction with the Wonca Asia Pacific 2012 conference being held in Jeju, South Korea, the Rajakumar Movement will hold its first ever pre-conference. It will be held on May 23, 2011. The topic of the day is *Age equity in Wonca*. There will be an opening address from Raj's good friend Datuk Dr Daniel Thuraiappah, current vice-president of the Wonca Asia Pacific region.

There will of course be time for Rajakumar Movement members to catch up. Numbers for the event are not limited and there will be a nominal fee of USD 20 to cover catering. Affordable accommodation is being investigated.

For further information email Dr Naomi Harris:
rajakumarmovement@yahoo.com.au



Dr Naomi Harris presenting at a Rajakumar session in Cebu, in February 2011

WONCA WORKING GROUP NEWS

WORKING PARTY ON ETHICAL ISSUES PLAN FOR VIENNA 2012

At the Wonca Europe Conference 2000 in Vienna, Austria, the programme contained a special symposium entitled *Challenges to our Professional attitudes*. This full day symposium covered areas and time periods from the past to the present time where the medical profession in general or individual colleagues in particular have been or were involved in developments based on unique political situations: the Holocaust in Europe, the Apartheid in South Africa, torture of prisoners in areas of war, or the death penalty in the United States. Experts and eyewitnesses of these developments gave stunning insight into the circumstances how physicians could get involved and sometimes were even eager to get involved.

This symposium attracted a full auditorium and it was Prof Lotte Newman, the former chairman of the Royal College of General Practitioners and the former president of SIMG/ Wonca Europe who suggested that a Special Interest Group (SIG) on ethical issues in General Practice/Family Medicine be founded. This suggestion was picked up by the Wonca World executive and Prof Lotte Newman and Prof Manfred Maier were appointed convenors of this newly founded Wonca interest group.

The world conference 2001 in Durban, South Africa, was used to build a list of colleagues interested in participating actively in this new Special Interest Group. In 2002, at the occasion of the Wonca Europe conference, in London, the group gathered to formulate the terms of reference: "to attempt to illustrate the nature of ethical issues encountered by Wonca and its members and to explore the principles, values and beliefs which inform decisions".

Further, the aims of the SIG were formulated:

- To identify common principles of ethical dilemmas
- To consider circumstances that favour the development of ethical dilemmas
- To raise awareness about ways to solve some of these ethical dilemmas
- To develop an instrument useful to access professional attitudes

Since then, the proceedings of the special symposium from Wonca Europe Vienna 2000 were published. The list of interested colleagues increases continuously and the group has tried to identify GP working groups on ethical issues around the globe. In addition, the group has reviewed the teaching situation for professional attitudes worldwide, has introduced a forum for discussion of ethical issues and tries to motivate colleagues to initiate similar activities back home in their association or home country. These activities are promoted at almost every Wonca Europe conference and all Wonca world conferences by organizing a special symposium on selected topics such as inequities in health, conflicts of interests, end of life care, etc. So far, the activities of the group, which became a Working Party at the Wonca world conference 2010, in Cancun, Mexico, usually attract an interested crowd - sometimes it has proved difficult to accommodate all participants in the room provided! (Kos). After the retirement of Prof Lotte Newman, Prof Micky

Weingarten from Israel jumped in and was a tremendous help in every way to keep the Working Party running and to make it attractive for colleagues globally.

The group plans to raise awareness of the importance of professional attitudes at every level of medical education and supports the idea to establish General Practice and Family Medicine as the leading discipline to teach medical ethics/professional attitudes, to students or colleagues. Further, the group would like to provide a reference for how to teach medical ethics and would like to design an assessment instrument for professional attitudes ready to get implemented in daily practice; in addition, the group aims to support the publication of ethical dilemmas relevant and of interest to colleagues worldwide.

During Wonca Europe 2012 – again taking place in Vienna (!) – we are planning to look back at the last 12 years and to assess what has been achieved in the field of ethical issues in General Practice/ Family Medicine. There will be ample room for seminars or workshop on this topic. We invite all colleagues to submit abstracts for this conference which has as a main theme The art and science of General Practice and Family Medicine. This theme aims to point out the difficult working situation of General Practitioners worldwide which base their decisions on sound scientific evidence but are challenged by achieving its implementation at the individual patient level. This requires skills and tolerance and sometimes a degree of understanding which could be considered “the art of practicing medicine”.

In addition, abstracts are welcomed in any field, related and relevant for General Practice and Family Medicine since there are no pre-designed topics besides the main theme of the conference.

We hope to see as many of you in Vienna as possible!

Sincerely,

Prof Manfred Maier
Chair Wonca Europe Vienna 2012 scientific committee and convener of Wonca Working party on ethical issues.

PROFILE: MANFRED MAIER

- Chair Wonca working party on ethical issues

-Chair scientific committee Wonca Europe Vienna 2012



Prof Manfred Maier

After completion of his basic medical education at the Medical faculty in Vienna, in 1975, Dr Maier started his vocational training to become a general practitioner. Since being licensed, in 1979, he works as a GP in his free time, either together with his wife Elisabeth in her health care practice or for the emergency health care service in Vienna, Austria.

Dr Maier started his research activities during his vocational training where he conducted clinical studies. He joined the Medical Faculty in Vienna, in 1979, and spent a postdoctoral fellowship at Harvard Medical School, in Boston, where he conducted experimental studies in the field of renal haemodynamics using methods from biochemistry, immunology, physiology and molecular biology.

In 1990, he was elected head of the newly formed special unit for General Practice at the Medical Faculty, in Vienna. Since then, he has developed a network of approximately 100 general practices, which participate in teaching and research in the field of general practice and has put special emphasis on staff development. The institution became an independent department in 2001 and Dr Maier was appointed professor and chairman, the six in 2004. In the same year, the Department of General Practice together with 6 other departments formed the new Center for Public Health at the Medical University of Vienna, of which Dr Maier has been head since.

Current research initiatives concentrate on registration of morbidity in Austria, development and evaluation of diagnostic and therapeutic methods useful in primary care and on evaluation and quality improvement of basic, vocational and continuing medical education in Austria.

Dr Maier is a member of several teaching and research organizations of Wonca and the “European Society for General Practice/ Family Medicine” such as the EGPRN or EURACT and has been chairman of the scientific

committee of the Wonca Europe conference Vienna in 2000. Following that conference, Dr Maier together with Dr Lotte Newman from the UK founded the Wonca working group on ethical issues, which Dr Maier currently chairs.

Dr Maier is now chairman of the scientific committee of another Wonca Europe conference to be held in Vienna, this time in 2012.

Dr Maier is married and has two children.

RURAL RENDEZ-VOUS 2012

The Wonca rural health conference to be held in Thunder Bay, Ontario, Canada is being called *Rendez-vous 2012*.

This conference will bring together the Wonca World Rural Health conference and The Network: Towards Unity for Health annual conference, as well as the next NOSM/Flinders conference on community engaged medical education, the Consortium for Longitudinal Curricula, and the Training for Health Equity Network.

The call for abstracts has just been released. *Rendez-vous 2012* conference sessions fall within four distinct learning formats. These formats have been designed to encourage for thought-provoking discussions and inquiry related to the conference themes of “engaging community participation in education, health, research, and service”. Engaging others in dialogue and conversation facilitates the process of research and scholarship combined with learning together, again, another important focal point in the delivery of our conference.

Conference themes are: community-engagement in health professional education; transforming health professional education globally; developing a culture for inter-professional learning and practice; innovations in longitudinal integrated curricula; social accountability in health profession education; advocacy of women and health.



Prof Roger Strasser, chair of the international advisory committee for Rendez-vous 2012 with Prof Bohumil Seifert, chair of the organising committee for Wonca Prague 2013

Abstracts will be accepted for the following four conference teaching and learning formats:

1. Workshops of 90 minutes, half a day or full day
2. Oral Presentations of 15 minutes
3. Thematic Posters of 90 minutes
4. 30 minute PeArLs (Personally Arranged Learning Sessions)

Personally Arranged Learning sessions (PeArLs) allow the presenter to present their narrative critical dilemma(s) in a way that allows the audience to actively participate in problem solving. The presenter will convey their problems and challenges in 2 – 3 minutes providing the context and highlight up to a maximum of three questions for small group discussion. Through a collaborative process generating ideas and solutions, small groups will discuss the issue and present back to the presenter(s) practical solutions. The presenter's responsibility will be to listen and clarify and not to direct or guide discussions. Truly conversational, this allows the presenter(s) to also learn from the diverse groups. Clarification of the nature of the other session types is available online.

Wonca world rural health rendez-vous 2012 at a glance

Dates: October 9-14, 2012

Venue: Thunder Bay, Ontario, Canada

Theme: Together and engaged

Deadline workshop submission: February 27, 2012

Deadline abstract submission (Oral/Poster): March 26, 2012

Early Bird Registration Closes: July 3, 2012

Web: <http://www.rendez-vous2012.ca/>

E-mail: rendez-vous2012@jpd.com

MEMBER AND ORGANIZATIONAL NEWS

SemFyc AND CIMF MEET IN SPAIN

The subregional Iberian peninsula congress of the Wonca Ibero-american region – CIMF was held in June, in Saragossa, are Spain.

At the opening ceremony, Wonca President, Prof Richard Roberts referred particularly to the important role that semFyc is playing in establishing and developing the Wonca Ibero-American Region (CIMF); and the boost that the assistance provided by semFyc has given to the member countries. Prof Roberts praised semFyc's generosity in devoting 0.7% of its budget to international cooperation projects and the excellent work being done by the semFyc 3rd and 4th World working group. He also reminded those present, in his reference to the round table on self-management, that at the opening of semFyc 2011 we were urged to *"keep an eye on the new developments that are emerging from various autonomous communities"* and *"not to be afraid of change"*. Finally, Prof Roberts expressed his pleasure at seeing semFyc presenting *"tangible proposals, such as the report on self-management"* which he deemed an excellent document.



Opening ceremony with (L to R) Josep Basora, president semFyc; Richard Roberts, president Wonca; Luis Aguilera, vice- president CIMF

SemFyc President Dr Josep Basora thanked Prof Roberts for his kind words before going on to remind his audience that *"there are no language barriers in the Ibero-American region – CIMF like those that exist in Wonca Europe (where everything is in English), which makes it easier to carry out our work"*. Dr Basora went on to discuss semFyc's social mission and funding of international cooperation projects, noting that the semFyc board set itself the mission of monitoring the recipient projects and their results. Reports on two such projects were to be presented at the first round table. Dr Basora also gave public thanks to the semFyc 3rd and 4th World and management working groups for their *"brilliant work and their contributions to the round tables at the Congress"*.

Finally, Dr Luis Aguilera, vice-president of Wonca Ibero-American Region – CIMF passed on greetings from the CIMF Board, reminded those present about the business dealt with at the previous two congresses, congratulated semFyc on bringing the region closer to its partners and suggested that all semFyc congresses should devote space to CIMF.

The first round table, entitled *Family Doctors and Solidarity – Cooperation Experiences*, was chaired by Dr Jesús Sepúlveda, coordinator

of the semFyc working group on the 3rd and 4th world. At it, Dr Diego A Fernández, of the Granada Association for Friendship with the Saharan Arab Democratic Republic, presented the project that was awarded 0.7% of the semFyc budget this year, *Development and Improvement of Primary Care in Wilaya de Dajla, a Saharan Refugee Camp in Tinduf Region (Algeria)*. Broadly speaking, the initiative consists of a three-year plan to send 26 aid workers to the refugee camps in groups of three - one family doctor, one family and community medicine resident and one nurse. Each group will travel to the region for a three week period to provide assistance and training and conduct research.

Next, Dr Francisco Beneyto, a family doctor, member of the semFyc 3rd and 4th working group and director of the Inter-Hospital Cooperation Council, presented the results for the project awarded 0.7% of the semFyc budget two years ago. Entitled *Support for the Primary Health Network in Morrumbala (Mozambique). Reinforcing the Derre and Chire Munire Health Centre*, this project was aimed at ensuring safe births and sexual and reproductive health, as well as creating surveillance posts on nutritional health and the treatment of malaria.

Finally, Dr Ethel Sequeira, former health coordinator for the Vicente Ferrer Foundation (2001-2007) member of the semFyc 3rd and 4th working group, presented the Vicente Ferrer Foundation's experience in consolidating the rural health network in Annapur district, Andhra Pradesh (India).

The intense debate that followed these presentations centred particularly on the contribution that participation in this type of development work can make to the formation of family doctors at both professional and personal level.

The next round table, on self-management, was chaired by Dr José



First round table with (L to R) Francisco Beneyto, Jesús Sepúlveda, Diego A Fernández, Ethel Sequeira

C Placín of the Aragon Directorate for Planning and Assurance. The first speaker was Dr Albert Casasa, family doctor with the EAP Sardenya primary care team in Barcelona, who presented the experience in self-management for primary care in Catalonia. Next, Dr Juan de Dios Alcántara, a member of the working group on the Clinical Management Model for Primary Care in the Andalusian Health Service, presented *Self-management: the Vision from Andalusia*. The following speaker was Dr Josep M Coll, a member of the semFYC working group on management, who presented the semFYC report on self-management.

Finally, Dr Vitor Ramos, representing the Portuguese Association of General Practitioners (APMCG), addressed the round table on the subject of primary care reform in Portugal 2005-2011.

The long and fascinating discussion that followed these presentations made it clear that the most interesting initiatives have been launched in Spain, and that semFYC has developed a project of the highest quality.

In short, this was a very full, most interesting and participatory session that left all those who took part highly satisfied.

José Miguel Bueno Ortiz

AAFP GLOBAL HEALTH WORKSHOP: STUDENTS ADD VALUE

The authors of the Wonca/WHO Guidebook on *Improving Health Systems: The Contribution of Family Medicine* concluded that family medicine has the flexibility and capacity to make a special contribution to health care in any national context.

The American Academy of Family Physicians (AAFP) annual Family Medicine Global Health workshop held in San Diego, October 13-15, adopted this premise as its thematic by-line; and served as a forum for AAFP members and international participants to elaborate and reflect upon the role family medicine plays in improving health systems and affecting health care delivery approaches.

Acknowledging Barbara Starfield

In his greetings to the workshop participants, Dr Dan Ostergaard, Wonca North America Regional President and AAFP Vice President, paid tribute to Professor Barbara Starfield whose name is profoundly interconnected with the very essence of health systems development and improvement. Dr Ostergaard highlighted the tributes made on behalf of the AAFP, American Medical

Association, Wonca and Johns Hopkins School of Public Health.



Dan Ostergaard MD, AAFP Vice President and Wonca North America Regional President, and Dr Karen Kinder PhD, Director of European Operations, Johns Hopkins School of Public Health during a networking break at the conference in San Diego

Dr Karen Kinder, Director of European Operations from Johns Hopkins School of Public Health, who was the opening plenary session speaker, emphasized the importance of primary care to improve the health status of populations as well as decrease health care costs. Her presentation on how information can improve equity and efficiency in the delivery of primary health care highlighted various tools, in particular Primary Care Assessment Tools (PCAT), designed by Dr Starfield and her colleagues to help capture a patient's experiences within the health system to ensure that decisions are based on the needs of the individual patient and population served.

One of the plenary sessions explored the complex dynamics of health professional migration. A

panel consisting of family medicine residency program directors from the United States (US) and abroad, and immigrant physicians in the US shared their personal narratives and discussed the benefits and drawbacks of health professional migration.

Melbourne manifesto re-emphasized

The *Melbourne Manifesto*, developed by the delegates of the Rural Wonca meeting in Melbourne, May 2002, was re-emphasized as an important code of practice document to adhere to when doing international recruitment of health professionals.

Increasing the number of workshop attendees from resource-constrained countries was one of the recommendations of 2010 workshop participants. In discussions and through their evaluations, they strongly suggested that interaction with international colleagues, especially from the countries and regions where AAFP members provide technical assistance in establishing and improving primary care, family medicine, human resources for health and medical education, would ensure even more variety of opinions. In addition, such international exchange would also enhance participant's vision and understanding of what really works in global health. The workshop planning committee put additional effort to bring more international participants to this year's workshop by communicating with US-based programs that are involved in United States Government grant implementation in different parts of the world.

Visitors from Ethiopia

One such program was the Medical Education Partnership Initiative (MEPI) which is funded by the USAID through the National Institute of Health Fogarty International Center and is

implemented by African institutions in 12 Sub-Saharan countries. In Ethiopia, Addis Ababa University (AAU) leads a consortium of the country's medical schools in partnership with four U.S.-based medical schools to improve the quality of medical education and retention. Through the MEPI, a group of Addis Ababa University educators was invited to come to the US to participate in a fellowship program coordinated by the University of Wisconsin. The time of their fellowship coincided with the workshop in San Diego, which allowed two of the educators from Addis Ababa to take part in the AAFP conference.



Dr Cindy Haq, Professor of Family Medicine and Population Health Sciences, University of Wisconsin, with her colleagues from Ethiopia – Drs Dereje Gulilat (middle), Dean of the AAU Faculty of Medicine, and Amha Mekasha Wondimagegnehu, AAU Faculty of Medicine faculty member.

Dr Dereje Gulilat, Dean of the AAU Faculty of Medicine, made a general session presentation on *Preparing for Family Medicine in Ethiopia*. His colleague, Dr Amha Mekasha Wondimagegnehu, co-presented the breakout session *Introducing Post Graduate Training for Family Medicine in Ethiopia: The story so far* led by Jane Philpott, MD, University of Toronto, and Cindy Haq, MD, University of Wisconsin.

Other international attendees included family medicine educators and physicians from Australia, Brazil, Canada, Japan and Lebanon.

Medical student involvement

This year's workshop surpassed all previous years' attendance numbers with students and residents significantly contributing to this increase. Their participation has noticeably grown in the last two years which is viewed as an extremely positive trend for future workshops and important evidence of their growing interest in global health. Many of them presented their international health experiences as posters and appreciated an opportunity of information exchange, which "included feedback we will use to guide our clinic's future direction" – said Kirk Wyatt, a second-year medical student from Mayo Medical School.



Will Bynum, MD (left), a family medicine resident, and Cory Janney, a medical student from University of South Carolina, present a poster about their experience with a medical student-run non-profit organization "Medical Students for Burn Care International".

Rochelle Molitor, also a second-year student from Mayo Medical School, pointed out that this conference really opened her eyes to all of the projects initiated by family medicine physicians. "While we learn quite a bit about the value of family medicine in the future of United States healthcare, I was previously unaware of the extent of involvement of family medicine globally. I appreciated witnessing the flexibility and global applicability of the specialty, as well as seeing the incredible amount of value that can be conferred in these situations by family medicine practitioners".



Javier Sevilla-Martir, MD, Associate Professor of Family Medicine, Indiana University, and his mentee, Joanna Campodonico, a medical student and poster presenter, discuss their poster during the Networking Reception.

In their evaluations participants unanimously agreed that networking and the variety and richness of presentations were the two most valuable features of the workshop. The content of the workshop program as well as the workshop format allowed for meaningful networking and exchange of ideas. Breaks between presentations, common interest lunches and two networking receptions provided ample opportunities for participants to get to know each other and tell what they are doing and where. “The workshop did make me aware of the complexities involved in global health but at the same time helped me narrow down my focus” – said one of the participants.

In summary

Final conference statistics include six general sessions, 27 breakout sessions, seven of which were repeated twice, 48 peer presentation sessions (twice as many as in 2010) and 35 posters (12 more than in 2010). All presentations displayed a remarkable diversity of topics, projects, programs and initiatives implemented throughout the world.

The workshop was made possible thanks to the financial support from the AAFP Foundation.

The 2012 Family Medicine Global Health Workshop will be held in Minneapolis, Minnesota, USA, September 6-8, 2012. For information about the workshop registration, hotel accommodation and abstract submission please go to www.aafp.org/intl/workshop or contact Rebecca Janssen, rjanssen@aafp.org

Alex Ivanov, MBA
AAFP Manager, International Activities

AAFP'S NEW PRESIDENT'S MESSAGE FOR FAMILY PHYSICIANS

‘Be part of the unstoppable force of family medicine’

The American Academy of Family Physicians’ (AAFP) new president Glen Stream, MD, of Spokane, Washington, stood before his family physician colleagues at the opening ceremony of the AAFP Scientific Assembly and reminded them of the challenges the specialty of family medicine faces.

‘Every day, some procedural subspecialist tells a medical student, ‘You’re too smart to be a family physician,’ said Stream. ‘We’re going to change that,’ he added.



AAFP’s new president Glen Stream MD

Stream spoke of the tension between what often are referred

to as ‘cognitive versus procedural’ physicians and reminded his audience that even though many people place family medicine in the cognitive category of medical specialties, the list of medical procedures routinely performed by family physician is impressive.

‘We’ve delivered babies, injected joints, set fractures and placed casts, performed endoscopic procedures and coloscopies, done minor and even major surgical procedures,’ said Stream. ‘Our hands are the hands of the most capable, comprehensive and compassionate physicians known.’

Stream told his audience that family physicians must go beyond providing the best possible medical care to America’s patients. ‘We have an ethical obligation to transform our health care system,’ complete with a solid family medicine foundation.

New president to use social media

AAFP members have some new options when it comes to communicating with their elected leader. After being introduced as president on September 14, Glen Stream, MD, said he plans to use social media to reach out to Academy members.

Stream emphasized similar ideas in AAFP leader voices, a new blog that launched on the same day.

<http://blogs.aafp.org/cfr/leadervoices/>

The new AAFP president said in his speech and in his blog entry that he plans to use Twitter to give members regular updates on his activities. Follow him @aafpprez. Stream also has a new Facebook account that will provide updates as well.

<http://www.facebook.com/AAFPPresident>

‘Collectively, our hands must not just treat one patient at a time, but also be the force that transforms our dysfunctional system,’ Stream added. Far too many people view America’s health care system as an entity so glutted with special interest groups seeking to maintain the status quo that the system cannot be changed, much like an immovable object, according to Stream. But, he noted, ‘I don’t believe in immovable objects. I believe in unstoppable forces.’

Stream called family medicine the unstoppable force that would transform America’s dysfunctional health care system.

Recalling his college physics class, Stream reminded his audience of famed English physicist and mathematician Sir Isaac Newton’s second law of motion: namely, *force equals mass times acceleration*. ‘To increase our force for change, we must increase both mass and acceleration,’ said Stream.

He told the audience that in 2011, the AAFP’s membership became a mass to be reckoned with when, for the first time, the Academy could boast of more than 100,000 members. Furthermore, said Stream, the Academy added to that ‘mass’ via coalitions with other primary care organizations that also understand family medicine’s in providing high quality and cost-effective health care.

The acceleration piece of Newton’s formula is apparent in the efforts of AAFP members and leaders as they engage in advocacy efforts with legislators and embrace the Academy’s federal political action committee, known as FamMedPAC, as its sphere of influence broadens, said Stream.

He praised students, residents and recently trained family physicians for their energy and deep commitment to the family medicine revolution. ‘They are our future, and that future is bright.’

The AAFP’s new president also acknowledged that the pace of such significant change is slow and often discouraging, but he reminded audience members that ‘perseverance is in our DNA.’ Case in point: Stream said it took him 10 years to convince his medical group to implement an electronic health record, and once he succeeded, he returned to school for a master’s degree in informatics so he’d be prepared to lead the implementation team. Perseverance in action.

Despite the challenges ahead, Stream urged the group in front of him to focus on the positive. ‘As so often happens when we discuss challenges, we forget to share

the joy and fulfillment we experience as family doctors,’ said Stream, and that’s a message medical students need to hear. ‘Being a family physician is the best job in the world, and I love being a family doctor. We are the most complete physicians. We are partners with our patients working toward their best possible health. America needs us to be the foundation for the future.’

Stream urged his colleagues to celebrate being family physicians and then return home from Orlando with renewed vigor. ‘Reach out to members of Congress, precept medical students in your office, be more involved in your Academy,’ he said. ‘That’s how we’ll create a better American health care system.’

Above all else, dare to dream the impossible dream, said Stream. ‘Be part of the unstoppable force of family medicine.’

Article courtesy of AAFP News Now, adapted from article written by Sheri Porter.

NEWS FROM CANADA

CFPC announces its 2011-2012 Executive Committee

The College of Family Physicians of Canada (CFPC) held another successful Family Medicine Forum from November 3-5, in Montreal. The meeting saw a change of president and new Executive Committee for the CFPC.

- President: Dr Sandy Buchman, Toronto, ON
- Past President: Dr Rob Boulay, Miramichi, NB
- President-Elect/Chair of the Board: Dr Marie-Dominique Beaulieu, Montreal, QC
- Honorary Secretary-Treasurer: Dr Kathy Lawrence, Regina, SK
- Member-at-Large: Dr Garey Mazowita, Vancouver, BC
- Member-at-Large: Dr Nirvair Levitt, Vancouver, BC
- Executive Director & CEO CFPC: Dr Calvin Gutkin, Mississauga, ON



**New President:
Sandy Buchman,
MD, CCFP, FCFP**

Dr Sandy Buchman received his medical degree from McMaster University and completed his Family Medicine Residency training at the University of Toronto.

New President, Dr Sandy Buchman, le nouveau président

Dr Buchman has practiced comprehensive family medicine in Mississauga, Ontario for 22 years. He is currently Education Lead and a Family Physician Practicing in Palliative Care at the Temmy Latner Centre for Palliative Care in Toronto and also serves as the Primary Care Lead for the Toronto Regional Cancer Program at Cancer Care Ontario. Dr Buchman teaches family medicine at the University of Toronto and McMaster University, and supervises residents at the Mount Sinai Hospital Academic Family Health Team.

Dr Buchman joined the CFPC's National Executive Committee in 2010 and served as Secretary- Treasurer, and then Chair of the Board. Currently, he is Chair of the Task Force on the CFPC's Relationship with the Pharmaceutical/Healthcare Industry; a member of the CFPC's Governance Advisory Committee; Co-chair of the Transitions in Care Steering Committee with the Canadian Partnership Against Cancer; and a member of the CFPC's Section of Family Physicians with Special Interests or Focused Practices Council.

Dr Buchman served as President of the Ontario College of Family Physicians (OCFP) in 2006–2007 and will receive the OCFP's 2011 *Award of Excellence* for his leadership in primary care for the Toronto Regional Cancer Program of Cancer Care Ontario. Dr Buchman was also awarded Canada's *Family Physicians of the Year* for the Southern Region in Ontario by the OCFP in 2004.

President-Elect and Chair of the Board : Marie-Dominique Beaulieu MD, CCFP, FCFP

Dr Marie-Dominique Beaulieu completed her medical degree and Family Medicine Residency at Laval University in Quebec. She trained as a Research Fellow at McGill's

Kellogg Centre for Advanced Studies in Primary Care.

Dr Beaulieu has practiced comprehensive family medicine for the last 33 years. She practices at the Family Medicine Group of Hôpital Notre-Dame du CHUM and is a Professor with the Department of Family Medicine at the University of Montreal.

Dr Beaulieu conducts primary care research at the Centre de recherche du Centre Hospitalier Universitaire de Montréal. Her research focuses on the implementation of primary care reform in Québec, specifically on the development of family medicine groups and interventions to foster high-quality primary care. She has also been involved in the development of clinical practice guidelines and policies at the national and provincial levels.

In April 2010, Dr Beaulieu was appointed Scientific Director of the Primary Care Division of the Agence d'évaluation des technologies et modes d'intervention en santé (AETMIS) du Québec.

In 2005, Dr Beaulieu was acknowledged as the Family Physician of the Year for the Province of Québec by the Collège Québécois des médecins de famille, and received the Reg L Perkin Award from The College of Family Physicians of Canada.

For further information contact:
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DES NOUVELLES DU CANADA

CMFC est fier d'annoncer son Comité de direction pour 2011-2012

Encore une fois, le Forum en médecine familiale du Collège des médecins de famille du Canada (CMFC), qui s'est déroulé à Montréal du 3 au 15 novembre, a connu un franc succès. Lors de la réunion, un nouveau président et un nouveau Comité de direction du Collège ont été nommés.

Président : Dr Sandy Buchman, Toronto, Ont.

Présidente sortante: Dr Robert Boulay, Miramichi, N-B.

Président désigné/Président du Conseil: Dre Marie-Dominique Beaulieu, Montreal, Que

Secrétaire trésorière honoraire: Dre Kathy Lawrence, Regina, Sask

Représentante des membres: Dr Garey Mazowita, Vancouver, C-B.

Représentante des membres: Dre Nirvair Levitt, Vancouver, C-B.

Directeur général et chef de la direction CMFC: Dr Calvin Gutkin, Mississauga, Ont.

Le nouveau président: le Dr Sandy Buchman

Le 15 octobre 2010, le Collège des médecins de famille du Canada (CMFC) accueillait fièrement son 57e président, le Dr Sandy Buchman

Diplômé de la faculté de médecine de l'Université McMaster à Hamilton (Ontario), le Dr Sandy Buchman a fait sa résidence en médecine familiale à l'Université de Toronto.

Pendant 22 ans, il a exercé la médecine familiale complète et globale à Mississauga (Ontario). Il est présentement directeur de l'éducation et médecin de famille praticien en soins palliatifs au *Temmy Latner Centre for Palliative Care* de Toronto. Il est aussi directeur des soins de première ligne pour le Programme régional de cancérologie de Toronto à Action Cancer Ontario. Il enseigne la médecine familiale à l'Université de Toronto et à l'Université McMaster et supervise les résidents de l'équipe universitaire de santé familiale de l'hôpital Mount Sinai.

Le Dr Buchman s'est joint au Comité national de direction du CMFC en 2010 et a agi à titre de secrétaire-trésorier, puis de président du Conseil. Présentement Il est président du Groupe de travail sur les relations avec l'industrie pharmaceutique/des soins de santé; co-président du Comité directeur sur les transitions dans les soins avec le Partenariat canadien contre le cancer; membre du Comité consultatif sur la gouvernance et membre du Conseil de la Section des médecins de famille avec intérêts particuliers ou pratiques ciblées du CMFC.

Le Dr Buchman a occupé le poste de président du Collège des médecins de famille de l'Ontario (CMFO) en 2006-2007 et il recevra le Prix d'excellence 2011 du CMFO pour son leadership dans le cadre du Programme régional de cancérologie de Toronto mis en œuvre par Action Cancer Ontario. En 2004, il a été reconnu par ses collègues du CMFO comme Médecin de famille de l'année pour la région du sud de l'Ontario.

Présidente désignée et présidente du Conseil : Marie-Dominique Beaulieu MD, CCMF, FCMF



Présidente désignée,
Marie-Dominique Beaulieu,
president-elect

Dre Marie-Dominique Beaulieu a obtenu son diplôme en médecine et complété sa résidence en médecine familiale à l'Université Laval à Québec. Elle a suivi une formation de Fellow en recherche au *Kellogg Center for Advanced Studies in Primary Care* à l'Université McGill.

Elle exerce la médecine familiale complète et globale depuis 33 ans. Elle pratique au

Groupe de médecine familiale de l'Hôpital Notre-Dame du CHUM et est professeure au Département de médecine familiale de l'Université de Montréal.

Dre Beaulieu effectue des recherches en soins primaire

au Centre de recherche du Centre Hospitalier Universitaire de Montréal. Ses travaux de recherche portent sur la mise en œuvre de la réforme des soins primaires au Québec, plus particulièrement les groupes de médecine familiale et les interventions visant à améliorer la qualité des soins primaires. Elle s'est également impliquée dans l'élaboration de guides et de politiques de pratique clinique en soins primaires aux paliers national et provincial.

En avril 2010, la Dre Beaulieu a été nommée directrice scientifique de la division des soins de premières ligne de l'Agence d'évaluation des technologies et modes d'intervention en santé (AETMIS) du Québec.

En 2005, elle a été reconnue comme Médecin de famille de l'année pour le Québec par le Collège québécois des médecins de famille et a reçu le prix Reg L. Perkin du Collège des médecins de famille du Canada.

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PROFILE: JULIO CEITLIN, HONOURED BY CFPC

The College of Family Physicians of Canada (CFPC) was proud to bestow Honorary Membership on Dr Julio Ceitlin MD, DPH from Buenos Aires, Argentina during the College's Family Medicine Forum hosted this year in Montreal, Quebec on November 3-5, 2011.

Honorary Membership to the CFPC is bestowed each year to a small number of outstanding individuals who are non-members of the College. They are recognized for their significant contributions to the CFPC or the discipline of family medicine and family practice and/or the health and well-being of the population in Canada or internationally.



Dr Julio Ceitlin

Dr Julio Ceitlin was presented with Honorary Membership in recognition of his leadership in the specialty of family medicine in South America, the impact of his work globally, and for his keen interest in, communication with, and recognition of the challenges faced by family medicine in Canada.

Dr Ceitlin is considered the founding father of family medicine in Argentina; he established the first Department of Family Medicine and residency program in 1984 and the Argentine Association of Family Medicine, introduced family medicine into the medical curriculum, and implemented the department of family medicine at a French hospital in Buenos Aires.

A medical graduate of the University of Buenos Aires Medical School, Dr Ceitlin became Program Director in the Pan-American Federation of Associations of Medical Schools (PAFAMS) in 1971. Through this role he directed the Community Medicine Program, an international program involving seven Latin-American countries.

The CFPC welcomes Dr Julio Ceitlin as a new Honorary Member of the College!

PROFIL: JULIO CEITLIN, HONORÉ PAR LE CMFC

C'est avec une grande fierté que le Collège des médecins de famille du Canada (CMFC) a conféré le titre de Membre honoraire au Dr Julio Ceitlin MD DPH, de Buenos Aires, Argentine, pendant le Forum en médecine familiale du CMFC qui s'est tenu à Montréal, du 3 au 5 novembre 2011.

Le titre de Membre honoraire du CMFC est conféré chaque année à un groupe restreint de personnes remarquables qui ne sont pas membres du Collège. Le Collège reconnaît leur contribution importante au CMFC ou à la discipline de la médecine familiale et/ou à la santé et au bien-être de la population du Canada ou du monde.

Le Dr Julio Ceitlin a reçu le titre de Membre honoraire en reconnaissance de son leadership au sein de la spécialité de la médecine familiale en Amérique du Sud, de l'impact de ses travaux sur la scène internationale, de son profond intérêt pour les défis qu'envisage la médecine familiale au Canada et pour sa capacité à les reconnaître.

Véritable pionnier de la médecine familiale en Argentine, le Dr Ceitlin a mis sur pied le premier département de médecine familiale et le premier programme de résidence à Buenos Aires en 1984. Il a fondé l'association de médecine de famille de l'Argentine, a intégré la médecine familiale dans le cursus médical et a fondé le premier département de médecine familiale dans un hôpital francophone de Buenos Aires.

Diplômé de la faculté de médecine de l'Université de Buenos Aires, le Dr Ceitlin est devenu le directeur

de programme de la fédération panaméricaine des associations des facultés de médecine (PAFAMS) en 1971. Dans ce rôle, il a dirigé le programme de médecine communautaire, un programme international qui regroupe sept pays d'Amérique latine.

C'est avec plaisir que le CMFC accueille le Dr Julio Ceitlin comme nouveau Membre honoraire du Collège!

RESOURCES FOR THE FAMILY DOCTOR

WMA STATEMENT ON THE GLOBAL BURDEN OF CHRONIC DISEASE

At the recent 62nd World Medical Association (WMA) General Assembly, in Montevideo, Uruguay, this statement on the global burden of chronic disease was adopted. Wonca organizational member, the American Academy of Family Physicians reports that a group of their members headed by Dr Ed Shahady and including members of the AAFP Center for International Health Initiatives developed the first draft of the statement and contributed a lot in the subsequent revision process.

This statement can be downloaded from <http://www.wma.net>

Introduction

Chronic diseases, including cardiovascular and circulatory diseases, diabetes, cancer, and chronic lung disease are the leading cause of death and disability in both the developed and developing world. Chronic diseases are not replacing existing causes of disease and disability (infectious disease and trauma), but are adding to the disease burden. Developing countries now face the triple burden of infectious disease, trauma and chronic disease. This increased burden is straining the capacity of many countries to provide adequate health care services. This burden is also undermining these nations' efforts to increase life expectancy and spur economic growth.

Ongoing and anticipated global trends that will lead to more chronic disease problems in the future include an aging population, urbanization and community planning, increasingly sedentary lifestyles, climate change and the rapidly increasing cost of medical technology to treat chronic disease. Chronic disease prevalence is closely linked to global social and economic development, globalization and mass marketing of unhealthy foods and

other products. The prevalence and cost of addressing the chronic disease burden is expected to rise in coming years.

Possible Solutions

The primary solution is disease prevention. National policies that help people achieve healthy lifestyles and behaviors are the foundation for all possible solutions.

Increased access to primary care combined with well designed and affordable disease-control programs can greatly improve health care. Partnerships of national ministries of health with institutions in developed countries may overcome many barriers in the poorest settings. Effective partnerships currently exist in rural Malawi, Rwanda and Haiti. In these settings where no oncologists are available, care is provided by local physicians and nurse teams. These teams deliver chemotherapy to patients with a variety of treatable malignancies

Medical education systems should become more socially accountable. The World Health Organization (WHO) defines social accountability of medical schools as the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region, or nation they have a mandate to serve. The priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public. There is an urgent need to adopt accreditation standards and norms that support social accountability. Educating physicians and other health care professionals to deliver health care that is concordant with the resources of the country must be a primary consideration. Led by primary care physicians, teams of physicians, nurses and community health workers will provide care that is driven by the principles of quality, equity, relevance and effectiveness.

Strengthening the health care infrastructure is important in caring for the increasing numbers of people with chronic disease. Components of this infrastructure include training the primary health care team, improved facilities, chronic disease surveillance, public health promotion campaigns, quality assurance and establishment of national and local standards of care. One of the most important components of health care infrastructure is human resources; well-trained and motivated health care professionals led by primary care physicians are crucial to success. International aid and development programs need to move from "vertical focus" on single diseases or objectives to

a more sustainable and effective primary care health infrastructure development.

Note: Depending on the country, different stakeholders will assume greater or lesser responsibility for change.

For World Governments:

1. Support global immunization strategies;
2. Support global tobacco and alcohol control strategies;
3. Promote healthy living and implement policies that support prevention and healthy lifestyle behaviors;
4. Set aside a fixed percentage of national budget for health infrastructure development and promotion of healthy lifestyles.
5. Promote trade policy that protects public health;
6. Promote research for prevention and treatment of chronic disease;
7. Develop global strategies for the prevention of obesity.

For National Medical Associations:

1. work to create communities that promote healthy lifestyles and prevention behaviors and to increase physician awareness of optimal disease prevention behaviors;
2. offer patients smoking cessation, weight control strategies, substance abuse counseling, self-management education and support, and nutritional counselling;
3. promote a team-based approach to chronic disease management;
4. advocate for integration of chronic disease prevention and control strategies in government-wide policies;
5. invest in high quality training for more primary care physicians and an equitable distribution of them among populations;
6. provide high quality accessible resources for continuing medical education;
7. support establishing evidence-based standards of care for chronic disease;
8. establish, support and strengthen professional associations for primary care physicians
9. promote medical education that is responsive to societal needs;
10. promote an environment of support for continuity of care for chronic disease, including patient education and self-management;
11. advocate for policies and regulations to reduce factors that promote chronic disease such as smoking cessation and blood pressure control;
12. support strong public health infrastructure; and
13. support the concept that social determinants are part of prevention and health care.

For Medical Schools:


1. develop curriculum objectives that meet societal needs; e.g., social accountability;
2. focus on providing primary care training opportunities that highlight the integrative and continuity elements of the primary care specialties including family medicine;
3. provide community-oriented and community-based primary care educational venues so that students become acquainted with the basic elements of chronic care infrastructure and continuity care provision;
4. create departments of family medicine that are of equal academic standing in the university; and
5. promote the use of interdisciplinary and other collaborative training methodologies within primary and continuing education programs.
6. Include instruction in prevention of chronic diseases in the general curriculum.


For Individual Physicians:


1. work to create communities that promote healthy lifestyles and prevention behaviors;
2. offer patients smoking cessation, weight control strategies, substance abuse counseling, self-management education and support, and nutritional counseling;
3. promote a team-based approach to chronic disease management;
4. ensure continuity of care for patients with chronic disease;
5. model prevention behaviors to patients by maintaining personal health;
6. become community advocates for positive social determinants of health and for best prevention methods;
7. work with parents and the community to ensure that the parents have the best advice on maintaining the health of their children.
8. Physicians should collaborate with patients' associations in designing and delivering prevention education.

**THE ART & SCIENCE
OF GENERAL PRACTICE**
18th WONCA EUROPE CONFERENCE
AUSTRIA CENTER VIENNA
JULY 4-7, 2012

2nd ANNOUNCEMENT





**WONCA
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2012**

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www.woncaeurope2012.org

WONCA CONFERENCES 2011 – 2013 AT A GLANCE

Information correct as of December 2011.
May be subject to change.

**Wonca Direct Members generally enjoy lower conference registration fees.
The level of discount is determined by the Host Organizing Committee of the conference.
See Wonca Website www.GlobalFamilyDoctor.com for updates & membership information

2011			
16 – 18 December	Wonca South Asia Regional Conference	Mumbai INDIA	Only Doctors Can Provide Accessible, Cost-beneficial and Equitable Healthcare
17 – 19 December	Wonca East Mediterranean Regional Conference	Dubai UNITED ARAB EMIRATES	A Family Doctor with you in all stages of Life
2012			
24 – 27 May	Wonca Asia Pacific Regional Conference	Jeju SOUTH KOREA	Evidence Based Approach to Primary Care
4 – 7 July	Wonca Europe Regional Conference	Vienna AUSTRIA	The Art and Science of General Practice
9 - 14 October	Wonca Rural Health Conference	Thunder Bay ONTARIO	Joint Conference with The Network towards unity for health
16 – 19 October	Wonca African Regional Conference	Victoria Falls ZIMBABWE	Roles and Responsibilities of African Family Physicians
2013			
26 – 29 June	20 th Wonca World Conference	Prague CZECH REPUBLIC	Family Medicine: Care for Generations

GLOBAL MEETINGS FOR THE FAMILY DOCTOR

MEMBER ORGANIZATION AND RELATED MEETINGS

Mental health and family medicine

Host : World Psychiatric Association with
Wonca working party on mental health
Date : February 8-11, 2012
Venue : Granada, Spain
Web : www.thematicconferencegranada2012.com

6th IPCRG world conference

Host : International Primary Care Respiratory Group
Date : April 25-28, 2012
Venue : Edinburgh, Scotland
Web : www.ipcrgrg-pcrs2012.com

EGPRN spring meeting

Host : European General Practice Research
network (EGPRN)
Theme : Quality improvement in the care of
chronic disease in family practice
Date : May 10-13, 2012
Abstracts close: January 15, 2012
Venue : Ljubljana, Slovenia
Web : www.egprn.org

EURIPA invitational forum

Host : European rural and isolated
practitioners association
Theme : Education and Training for rural practice
Date : May 11-13, 2012
Venue : Porto, Portugal
Web : www.euripa.org

RNZCGP conference for general practice

Host : The Royal New Zealand College of
General Practitioners
Theme : to be advised
Date : September 13-16, 2012
Venue : Rotorua, New Zealand
Web : www.rnzcgp.org.nz

RCGP annual national primary care conference

Host : Royal College of General Practitioners
Date : October 4-6, 2012
Venue : Glasgow, United Kingdom
Web : www.rcgp.org.uk

AAFP annual scientific assembly

Host : The American Academy of Family Physicians
Date : October 17-20, 2012
Venue : Philadelphia, USA
Web : www.aafp.org

EGPRN autumn meeting

Host: European General Practice Research network
(EGPRN)
Theme: Research on patient-centred inter-professional
collaboration in primary care.
Date : October 18-21, 2012
Abstracts close: June 30, 2012
Venue : Antwerp, Belgium
Web : www.egprn.org

RACGP GP '12 conference

Host : The Royal Australian College of
General Practitioners
Date : October 25-27, 2012
Venue : Gold Coast, Australia
Web : www.gp12.com.au/

Family Medicine Forum / Forum en médecine familiale 2011

Host : The College of Family Physicians of Canada
Le Collège de médecins de famille du Canada
Date : November 15-17, 2012
Venue : Toronto, Canada
Web : <http://fmf.cfpc.ca>